Approved: 2/12/96
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:00 a.m. on February 8, 1996 in Room 529-S of the Capitol.

All members were present.

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Judi Stork, Kansas Bank Department
Robert Storey, Union America Insurance
William Sneed, Health Insurance Association of America
Tom Wilder, Kansas Insurance Department
Kathy Speaker, Alzheimer's Association
Jayne Aylward, Kansas Department on Aging
David Hanson, Kansas Life Association

Others attending: See attached list

Judi Stork, Kansas Bank Department, requested introduction of a bill amending KSA 9-1104, pertaining to legal lending limits. (Attachment #1) Senator Steffes made a motion to introduce the requested legislation; Senator Clark seconded the motion. The motion carried.

Robert Storey, Union America Insurance, requested introduction of legislation concerning credit for reinsurance. (Attachment #2) Senator Emert moved to introduce the requested legislation; Senator Praeger seconded the motion. The motion carried.

William Sneed, Health Insurance Association of America, requested introduction of a bill to amend the law dealing with long term care insurance. (Attachment #3) Senator Emert made a motion to introduce the legislation as requested. Senator Corbin seconded the motion. The motion carried.

Senator Emert made a motion, seconded by Senator Steffes, to approve the minutes of the meeting of February 7 as submitted. The motion carried.

The chair opened the hearing on **SB 529**, concerning the mandatory reinstatement of certain life and long-term care insurance policies. Senator VanCrum had introduced this legislation but was prevented by illness from appearing at today's committee hearing. He did, however, submit written testimony explaining the intent of the legislation. (Attachment #4)

Kathy Speaker, Alzheimer's Association, spoke of the need to protect Alzheimer's patients and those with other mental incapacities. (Attachment #5)

At the request of the chair, Dr. Woolf explained that this bill allows that individual life and long term care policies will be eligible for reinstatement for one year after non-payment of premium upon the insured suffers from diagnosed mental incapacity.

Jayne Aylward, Kansas Department on Aging, testified that 34,250 Kansas are now diagnosed with Alzheimer's Disease and need the protection of measures such as this bill. (Attachment #6)

David Hanson, Kansas Life Insurance Association, stated his concerns with certain provisions of the bill and with some of the language, such as the definition of mental incapacity being too vague and indefinite and the term "insured" being used instead of "policy holder." (Attachment #7) Mr. Hanson also expressed concern about the notification requirements.

Senator Hensley questioned whether Mr. Hanson's group supported the concept of the bill, and Mr. Hanson replied that they do support this concept but do not feel this particular legislation will solve many of the problems.

MINUTES OF THE Senate Committee on Financial Institutions & Insurance, Room 529-S Statehouse, on February 8, 1996.

Tom Wilder, Kansas Insurance Department, submitted model NAIC language dealing with unintentional lapses of policies and stated that the Insurance Department supports this bill but suggests the deletion of section (b), on page 1, line 19. (Attachment #8) In response to Senator Bond's question, Mr. Wilder felt the legislation should not be limited to long-term care, that it is valuable to life insurance policy holders also.

The hearing on **SB 529** was closed. The chair requested Mr. Wilder and Mr. Hanson to meet with Senator VanCrum to work out the problems with the language and report back to the committee.

Judi Stork, State Bank Department, appeared as a proponent of **SB 571**, concerning reduction of capital stock of a bank or trust company. (Attachment #9) Ms. Stork explained that the bill moves the approval process to reduce capital stock from the State Banking Board to the Bank Commissioner and adds new language to permit a bank to reduce its capital stock account below minimum level by transferring those funds to their surplus account. Currently there is no mechanism in the statutes to allow a bank which over estimates its projected five year deposit growth to make an adjustment in its capital stock account.

Senator Bond suggested that "board" should be changed to "Banking Board" throughout the bill as necessary for purposes of clarification. Ms. Stork agreed with these changes and the hearing was closed.

Senator Emert made a motion to amend **SB 571** as suggested, and to pass the bill favorably as amended. Senator Steffes seconded the motion. The motion carried.

The committee adjourned at 10:00 a.m. The next meeting is scheduled for February 12, 1996.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/8/96

NAME	REPRESENTING
Bill Sneed	NIAA
Bob Storey	Unitarian Ins
David Worley	Interested Party
Kelly Kultala	KTLA
Margie Pressgrove	Intern Hale, Intern
Kathleen Monow	SRS/MH&DD
Carol Ridgway	Ks Ins Dept
Roger Toenzke	FFC
Jake Reisinger	KDOA
Kathy Sparks	Ag Lenders Association
Wayne Maichel	KDOA
TAD KRAMER	SECURITY BENEFIT
Tom Wilder	Kansas Ins. Dept
Kent Peterson	Prudential
John D. Solbach	Delta Dental
David Hanson	Ks Life Assoc
Judi Stork	OSBC

KSA 9-1104

(a) **Definitions.** For purposes of this section, the following definitions apply:

(1) "Borrower" shall include an individual, sole proprietorship, partnership, joint venture, association, trust, estate, business trust, corporation, limited liability company, not for profit corporation, government unit or agency, instrumentality, or political subdivision thereof, or any similar entity or organization.

(2) "Capital" means the total of capital stock, surplus, undivided profits, 100% of the allowance for loan and lease loss, capital notes and debentures, and reserve for contingencies. Intangibles, such as goodwill, shall not be included in the definition of capital when determining lending limits.

(3) "Loan" includes:
(i) a bank's direct or indirect advance of funds to or on behalf of a borrower based on an obligation of the borrower to repay the funds;
(ii) a contractual commitment to advance funds;
(iii) an overdraft;
(iv) loans that have been charged off the bank's books in whole or in part, unless the loan is unenforceable by reason of:
(A) discharge in bankruptcy;
(B) expiration of the statute of limitations;
(C) judicial decision; or
(D) the bank's forgiveness of the debt.

(b) **General Lending Limit Rule.** Subject to the rules set forth in (d), (e) and (f), loans to one borrower, including any bank officer or employee, shall not exceed 25% of a bank's capital.

(c) **Calculation of the Lending Limit.**

(1) The bank's lending limit shall be calculated on the date the loan or written commitment is made. The renewal or refinancing of a loan shall not constitute a new lending limit calculation date unless new funds are advanced.

(2) If the bank's lending limit increases subsequent to the origination date, a bank may use the current lending limit to determine compliance when advancing funds. An advance of funds includes the lending of money or the repurchase of any portion of a participation.

(3) If the bank's lending limit decreases subsequent to the origination date, a bank shall not be prohibited from advancing on a prior commitment that was legal on the date the commitment was made.

(d) **Exemptions.** That portion of a loan which is continuously secured on a dollar for dollar basis by any of the following will be exempt from any lending limit.

(1) Government Guaranties. A guaranty, commitment or agreement to take over or to purchase, made by any Federal Reserve Bank or by any department, bureau, board, commission, agency, or establishment of the United States of America, including any corporation wholly owned, directly or indirectly by the United States;

(2) Time Deposit Accounts. A perfected interest in a time deposit account(s) in the lending bank. In the case of a time deposit which may be withdrawn in whole or in part prior to maturity, the bank shall establish written internal procedures to prevent the release of the deposit;

(3) Bonded Warehouse Receipts. A bonded warehouse receipt issued to the borrower by some other person;

(4) U.S. Government Bonds. Treasury bills, certificates of indebtedness, or bonds or notes of the United States of America or instrumentalities or agencies thereof, or those fully guaranteed by them;

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(5) State General Obligation Bonds. General obligation bonds or notes of the State of Kansas or any other state in the United States of America;

(6) Municipal General Obligation Bonds. General obligation bonds or notes of any Kansas municipality or quasi municipality; or

(7) Repurchase Agreements. A perfected interest in a repurchase agreement of U.S. government securities with the lending bank.

(e) **Special Rules.**

(1) The total liability of any borrower may exceed the general 25% limit by up to an additional 10% of the bank's capital. To qualify for this expanded limit:

(i) the bank shall have as collateral a first lien or liens on real estate securing a portion of the liability equal to at least the amount by which the total liability exceeds the 25% limit;

(ii) the amount of the recorded lien or liens and the appraised value of the real estate shall each equal at least twice the amount of the excess liability; and

(iii) a portion of the loan equal to at least the excess liability shall have installment payments sufficient to amortize that portion within 20 years.

(2) That portion of any loan endorsed or guaranteed by a borrower will not be added to that borrower's liability until the endorsed/guaranteed loan is past due ten days.

(3) If the total liability of any active bank officer will exceed $50,000, prior approval from the bank's board of directors shall be noted in the minutes.

(4) To the extent they are insured by the Federal Deposit Insurance Corporation, time deposits purchased by a bank from another financial institution shall not be considered a loan to that financial institution and shall not be subject to the bank's lending limit.

(5) Third party paper purchased by the bank will not be considered a loan to the seller unless and until the bank has the right under the agreement to require the seller to repurchase the paper.

(f) **Combination Rules.**

(1) General rule. Loans to one borrower will be attributed to another borrower and their total liability will be combined --

(i) When proceeds of a loan are to be used for the direct benefit of the other borrower, to the extent of the proceeds so used; or

(ii) When a common enterprise is deemed to exist between the borrowers.

(2) Direct benefit. The proceeds of a loan to a borrower will be deemed to be used for the direct benefit of another person and will be attributed to the other person when the proceeds, or assets purchased with the proceeds, are transferred to another person, other than in a bona fide arm's length transaction where the proceeds are used to acquire property, goods, or services.

(3) Common enterprise. A common enterprise will be deemed to exist and loans to separate borrowers will be aggregated:

(i) When the expected source of repayment for each loan or extension of credit is the same for each borrower and neither borrower has another source of income from which the loan, together with the borrower's other obligations, may be fully repaid;

(ii) When both of the following circumstances are present:

(A) Loans are made to borrowers who are related directly or indirectly through common control, including where one borrower is directly or indirectly controlled by another borrower. Common control means: 1)to own, control or have the power to vote 25 percent or more of any class of voting securities or voting interests; 2) controls, in any manner, the election of a majority of the directors; or 3) has the power to exercise

a controlling influence over the management or policies of another person; and

(B) Substantial financial interdependence exists between or among the borrowers. Substantial financial interdependence is deemed to exist when 50 percent or more of one borrower's gross receipts or gross expenditures (on an annual basis) are derived from transactions with the other borrower. Gross receipts and expenditures include gross revenues/expenses, intercompany loans, dividends, capital contributions, and similar receipts or payments; or

(iii) When separate persons borrow from a bank to acquire a business enterprise of which those borrowers will own more than 50 percent of the voting securities or voting interests, in which case a common enterprise is deemed to exist between the borrowers for purposes of combining the acquisition loan.

An employer will not be treated as a source of repayment for purposes of determining a common enterprise because of wages and salaries paid to an employee.

(4) Special rule for loans to a corporate group.

(i)Loans by a bank to a borrower and the borrower's subsidiaries shall not, in the aggregate, exceed 50 percent of the bank's capital. However, at no time shall loans to any one borrower or to any one subsidiary exceed the general lending limit of 25%, except as allowed by other sections of this statute. For purposes of this paragraph, a corporation or a limited liability company is a subsidiary of a borrower if the borrower owns or beneficially owns directly or indirectly more than 50 percent of the voting securities or voting interests of the corporation or company.

(ii)Loans to a borrower and a borrower's subsidiaries that do not meet the test contained in (4)(I), will not be combined unless either the direct benefit or the common enterprise test is met.

(5) Special rules for loans to partnerships, joint ventures, and associations.

(i) For purposes of subsection (f)(5), the term partnership shall include a partnership, joint venture, or association. The term partner shall include a partner in a partnership or a member in a joint venture or association.

(ii) General partner. Loans to a partnership are considered to be loans to a partner, if by the terms of the partnership agreement that partner is held generally liable for debts or actions of the partnership.

(iii) Limited partner. If the liability of a partner is limited by the terms of the partnership agreement, the amount of the partnership debt attributable to the partner is in direct proportion to their limited partnership interest.

(iv) Notwithstanding the provisions of subsection (5)(ii) and (5)(iii) above, if by the terms of the loan agreement the liability of any partner is different than delineated in the partnership agreement, for the purpose of attributing debt to the partner the loan agreement will control.

(v) Loans to a partner are not attributed to the partnership unless either the direct benefit or the common enterprise test is met.

(vi) Loans to one partner are not attributed to other partners unless either the direct benefit or common enterprise test is met.

(vii) When a loan is made to a partner to purchase an interest in a partnership, both the direct benefit and common enterprise tests are deemed to be met, and the loan is attributed to the partnership.

(6) Notwithstanding the other provisions of subsection (f), the Commissioner may determine, based upon an evaluation of the facts and circumstances of a particular transaction, that a loan to one borrower may be attributed to another borrower.

(g) **Enforcement.**

The Commissioner may order a bank to correct any loan not in compliance with this statute. A violation of this statute shall be deemed corrected if that portion of the borrower's liability which created the violation could be legally advanced under current lending limits. Failure to comply with the Commissioner's order within 60 days shall be grounds for the proposed removal of a bank officer and/or director pursuant to K.S.A. 9-1805.

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MODEL LAW ON CREDIT FOR REINSURANCE

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Section 1. Credit Allowed a Domestic Ceding Insurer

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of 1A or B or C or D or E. If meeting the requirements of 1C or D, the requirements of 1F must also be met.

A. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state.

Drafting Note: A state which provides for licensing of reinsurance by line, for consistency should adopt an amended version of Section 1A requiring the assuming insurer to be "licensed to transact reinsurance in this state."

B. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. An accredited reinsurer is one which:

(1) Files with the Commissioner evidence of its submission to this state's jurisdiction;

(2) Submits to this state's authority to examine its books and records;

(3) Is licensed to transact insurance or reinsurance in at least one state, or in the case of a U.S. branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one state;

(4) Files annually with the Commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and either

(a) Maintains a surplus as regards policyholders in an amount which is not less than $20,000,000 and whose accreditation has not been denied by the Commissioner within ninety days of its submission; or

(b) Maintains a surplus as regards policyholders in an amount less than $20,000,000 and whose accreditation has been approved by the Commissioner.

No credit shall be allowed a domestic ceding insurer, if the assuming insurers' accreditation has been revoked by the Commissioner after notice and hearing.

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Drafting Note: To qualify as an accredited reinsurer, an assuming insurer must meet all of the requirements and the standards set forth in Section 1B. If the Director, Superintendent or Commissioner of Insurance determines that the assuming insurer has failed to continue to meet any of these qualifications, he may upon written notice and hearing revoke accreditation.

C. Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a U.S. branch of an alien assuming insurer is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or U.S. branch of an alien assuming insurer:

(1) Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

(2) Submits to the authority of this state to examine its books and records.

Provided, however, that the requirement of Subsection C(1) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

Drafting Note: The term "substantially similar" means standards which equal or exceed the standards of the enacting state, as determined by the Commissioner of the enacting state. It is expected that the NAIC will maintain a list of states whose laws establish standards which equal or exceed the standards of this model act.

D. (1) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in Section 3B, for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commissioner information substantially the same as that required to be reported on the NAIC Annual Statement form by licensed insurers to enable the Commissioner to determine the sufficiency of the trust fund. In the case of a single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000. In the case of a group including incorporated and individual unincorporated underwriters, the trust shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States ceding insurers of any member of the group; the incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and the group shall make available to the Commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants.

(2) In the case of a group of incorporated insurers under common administration which complies with the filing requirements contained in the previous paragraph, and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation; and submits to this state's authority to examine its books and records and bears the expense of the examination, and

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MEMORANDUM

TO: The Honorable Dick Bond, Chairman
Senate Financial Institutions and Insurance

FROM: William W. Sneed, Legislative Counsel
HIAA

DATE: February 8, 1996

RE: Bill Introduction - Long Term Care

Mr. Chairman and Members of the Committee, I am Bill Sneed and I am appearing today on behalf of the Health Insurance Association of America (HIAA). Attached to this memorandum is a proposed bill regarding long term care. With the passage of 1995 Senate Bill 8 and the accompanying regulations from the Kansas Insurance Department, we are requesting that your committee hear testimony on long term care insurance and its current status in Kansas.

Obviously, at the time of the hearing we will be most happy to present you with information specifically as to why we believe this legislation is appropriate. In the interim we respectfully requested this bill to be introduced and set for a hearing.

On behalf of HIAA, I appreciate presenting this to the committee and if you have any questions, please do not hesitate to contact me.

Respectfully submitted,

William W. Sneed

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AN ACT concerning long term care; amending K.S.A. 1995 Supp. 40-2,116 and K.S.A. 40-2228, and repealing the existing sections.

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

Section 1. K.S.A. 1995 Supp 40-2,116 is hereby amended to read as follows: 40-2,116. As used in this act:

(a) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(b) "Assisted living facility" means any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services including personal care or supervised nursing care available 24 hours a day, seven days a week for the support of resident independence. The provision of skilled nursing procedures to a resident in an assisted living facility is not prohibited by this act. Generally, the skilled service provided in an assisted living facility shall be provided on an intermittent or limited term basis, or if limited in scope, on a regular basis.

(c) "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

(d) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

~~(a)~~ *(e)* "Contracting facility" means a health facility which has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

~~(b)~~ *(f)* "Contracting professional provider" means a professional provider who has entered into a contract with a service corporation to provide services to subscribers of the service corporation.

(g) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(h) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(i) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

~~(c)~~ *(j)* "Health facility" means a medical care facility as defined in K.S.A. 65-425 and amendments thereto; psychiatric hospital licensed under K.S.A. 75-3307b and amendments thereto; adult care home, which term shall be limited to nursing facility, assisted living facility and residential health care facility ~~as such terms are defined in K.S.A. 39-923 and amendments thereto~~; and kidney disease treatment center, including centers not located in a medical care facility.

(k) "Nursing facility" means any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the

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administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations.

~~(d)~~ *(l)* "Professional provider" means a provider, other than a contracting facility, of services for which benefits are provided under contracts issued by a service corporation.

(m) "Residential health care facility" means any place or facility caring for six or more individuals not related within the third degree or relationship to the administrator, operator or owner by blood or marriage and who, due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes individual living units and provides or coordinates personal care or supervised nursing care available on a 24-hour, seven-day-a-week basis for the support of resident independence. The provision of skilled nursing procedures to a resident in a residential health care facility is not prohibited by this act. Generally, the skilled services provided in a residential health care facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis.

~~(e)~~ *(n)* "Service corporation" means a mutual nonprofit hospital service corporation organized under the provisions of K.S.A. 40-1801 et seq., and amendments thereto, a nonprofit medical service corporation organized under the provisions of K.S.A. 40-1901 et seq., and amendments thereto.

(o) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(p) "Transferring" means moving into or out of a bed, chair or wheelchair.

Section 2. K.S.A. 40-2228 is hereby amended to read as follows: K.S.A. 40-2228. (a) The commissioner may adopt reasonable rules and regulations:

(1) To establish specific standard 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, non-duplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definition of terms, *and provisions which condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or cognitive impairment*; 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 certificate-holder;

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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 he 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 effect 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 limitation 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)(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

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it complies with the provisions of this act.

(i) A long-term care insurance policy may pay benefits at a lower level for an assisted living facility and a residential health care facility than it pays for a nursing facility. However, the benefit paid for services provided in an assisted living facility or a residential health care facility shall not be less than 50% of the benefit payable for services provided in a nursing facility.

(j) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

(1) Activities of daily living shall include at least the following as defined in K.S.A. 1995 Supp. 40-2,116 and in the policy.

(a) Bathing;
(b) Continence;
(c) Dressing;
(d) Eating;
(e) Toileting; and
(f) Transferring.

(2) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in subsection (k) as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in subsections 1 and 2.

(l) For purposes of this act the determination of a deficiency shall not be more restrictive than:

(1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(m) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(n) Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

Section 3. K.S.A. 1995 Supp. 40-2,116 and K.S.A. 40-2228 are hereby repealed.

Section 4. This act shall take effect and be in force from and after its publication in the Kansas register.

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STATE OF KANSAS

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MEMBER: COMMERCE, LABOR AND REGULATIONS
COMMITTEE, NATIONAL CONFERENCE ON STATE LEGISLATURES
MEMBER: ENVIRONMENTAL TASK FORCE, COUNCIL ON STATE GOVERNMENTS

TESTIMONY FOR

FINANCIAL INSTITUTION AND INSURANCE COMMITTEE ON SENATE BILL 529

FROM SENATOR BOB VANCRUM

This bill relates to mandatory reinstatement of certain life insurance and long term care policies in case of the failure to pay a premium due to the mental incapacity of an insured. The goal is to prevent lapse of such policies in cases of alzheimer's and other diseases often afflicting the aging which cause memory loss.

This law allows for a policy to be reinstated if it's been in effect continuously for at least five years, if it's been without default in the payment of premiums during this period and if there's a subsequent unintentional default in premium payments caused by the mental incapacity of the insured. It goes on to define "mental incapacity" and the procedures for reinstatement.

Other states have passed similar anti-lapse laws. The life insurance provisions were borrowed from the Texas Act. It seems even more fair to apply the same rules to long-term care insurance, but I'll leave that to the committee's best judgement.

Senate 7/d-1
2/8/96
Attachment #4

February 8, 1996

To: Senate Finance Committee

From: Kathy Speaker, Vice President
Alzheimer's Association-Topeka, Chapter

Senate Bill # 529 is definitely needed in the State of Kansas. We need to protect those who cannot protect themselves!

Many calls do come into the Alzheimer's office regarding this problem. These families are referred to their attorneys.

We do question the policy having to have been effect for five years preceding lapse. We feel that most people have to be approved for certain life and long term care insurance before being accepted, so why put the five years into this bill?

Those in the early stages of Alzheimer's Disease may get confused one month when receiving an insurance bill and not the next. Most of the time is they set it down with all intentions of paying but forget where it was placed then assume it was paid!

From personal experience I know this happens. My mother at age 67 was diagnosed with Alzheimer's Disease. She is now in her later stages. I remember having to cancel her junk mail because she would pay for insurance policies which she never had! Then she would loose her gas and electric bill and I would have it turned back on. (This is a lady who kept excellent credit and paid any bill she had as it came in)

Now this past week I have experienced the same symptoms with my dad. He called me this last Sunday to meet him Monday morning. He asked if I had an attorney. Concerned I met him. He had received a letter in the mail stating he had won all 3 bonus package groups. I called the company right there. He had won $5,00 worth of coins (valued at $5.00). I went into great explanation with him. Tuesday morning he called to see what I had found out about the letter. He called me two more times that day at my office. The last time he had received a letter stating he had won ONE MILLION DOLLARS! He proceded to read me the fine print and I said "dad, I am on a business phone and will have to call you back tonight". I got off the phone and just cried.

Please pass this bill and help not only those suffering from Alzheimer's and those having mental incapacities but also this bill will help the families as it is devastating even for them!

Senate FI+I
2/8/96

Kathy Speaker

Attachment # 5

TESTIMONY ON SB 529
by
Jayne Aylward, Deputy Secretary, Kansas Department on Aging
to the
Financial Institutions and Insurance Committee
February 8, 1996

I am pleased to have this opportunity to testify on behalf of Senate Bill 529. As the Kansas Department on Aging understands the bill, life insurance policies and long-term care insurance policies which have been in existence for five or more years will, in effect, be eligible for reinstatement within one year of the date of lapse if the policy was the subject of a default due to the mental incapacity of the insured.

We believe this is an appropriate area of concern for the state.

Our remarks ought to be understood to focus on older Kansans, and our primary concern is for their well-being.

We want to focus on the older Kansans who, because of Alzheimer's and other allied diseases, have grown demented with age. About ten percent of older Kansans contract Alzheimer's or other mentally debilitating affliction. Right now, there are about 34,250 cases of Alzheimer's in Kansas among the population 65 and over. We believe that about 1,800 older Kansans suffer onset of one of these conditions annually.

For these people, the loss of short-term memory is coupled with certain disorienting circumstances. Taken together, it becomes quite likely that behaviors will include forgetting to pay insurance premiums, and even forgetting the role of insurance or the nature of a policy.

Senate Bill 529 requires that a policy be in effect for five years and not have a history of delinquent payments, so we are confident that it is directed toward persons who might be called high-quality policyholders. And included in the safeguards available to the industry is the fact that mental incapacity must be diagnosed by a qualified physician. But within those safeguards, consumers enjoy appropriate protection from their own affliction.

KDOA supports the ends sought to be reached by this bill, and supports this bill as an appropriate means of reaching those ends.

Senate FI&I
2/8/96
Attachment #6

Testimony on Senate Bill 529

Senate Financial Institutions and
Insurance Committee
State Capital Building
Topeka, KS

Re: Senate Bill 529

Chairman Bond and Members of the Committee:

I am David Hanson appearing on behalf of the Kansas Life Insurance Association, and Association of domestic life insurance companies here in Kansas. We appreciate this opportunity to address several concerns we have with provisions of Senate Bill 529.

We are concerned that some of the provisions of the Bill may be overly broad and create additional problems for the Companies and their insureds. Specifically, the Bill provides for reinstatement of a policy if there is an unintentional default in premium payments caused by mental incapacity of the insured. We are concerned this may have unintended consequences where the insured is not the same as the policy owner, since it is the policy owner who may fail to pay the premiums. We are also concerned that the proposed definition of mental incapacity is somewhat vague and indefinite.

We are also concerned that the disclosure provisions set forth in section 8 will be extremely difficult to comply with since it only applies to certain policies issued to residents of this state and Kansas would become only the second state (following Texas) to adopt such provisions. Tracking policy holders, contract holders and covered persons over the years to comply with such disclosure requirements will be extremely difficult.

We are also concerned that requiring reinstatement up to one year from the lapse of the policy due top non-payment is too long.

We appreciate your consideration of these concerns.

Respectfully,

David A. Hanson

DAVID A. HANSON

Senate 7/01
2/8/96
Attachment #7

American Council of Life Insurance

STATEMENT
OF
THE AMERICAN COUNCIL OF LIFE INSURANCE

SENATE BILL 529

Chairman Bond and Members of the Committee:

Thank you for the opportunity to comment on Senate Bill 529.

The American Council of Life Insurance is a trade association whose nearly 600 member companies hold 90% of the life insurance in force in America today. We have over 400 member companies licensed in Kansas.

Senate Bill 529 is troublesome from a public policy standpoint in that it singles out a particular class of person and grants them favorable treatment over others. The bill would require life and long-term care insurers to reinstate policies that have lapsed for non-payment of premiums for up to a year after the lapse if the insured could show that the failure to pay premiums was due to his or her "mental incapacity" at the time of the failure to pay.

It is, of course, unfortunate that a person would suffer from mental incapacity and as a result fail to pay their life or long-term care insurance premiums. It is not unreasonable to suggest, however, that the same mental incapacity might also cause them to fail to pay other financial obligations. Indeed, there are a variety of medical or financial circumstances that befall individuals which result in their failure to make payments on all kinds of contracts. Despite this, Senate Bill 529 would single out for special treatment only those individuals who fail to make payments as a result of mental incapacity and only the payments they fail to make on life insurance and long-term care contracts. While we have great sympathy for individuals who suffer a mental incapacity we believe singling them out for special treatment in this particular circumstance is not constructive public policy.

We further believe that there is great potential for fraudulent abuse of the protections proposed by the bill. An individual, with an entire year to act, could let his policy lapse for a variety of reasons, discover during that year the need for the policy's protection and with only a note from an accommodating physician gain reinstatement. The increased anti-selection risk posed to insurers by the bill is significant. A person not otherwise entitled to reinstatement would only need claim "mental incapacity" and the insurer would be obligated to reinstate.

Most life insurance policies (many of which include a provision for acceleration of benefits for long-term care) include a provision which allows the policy owner to reinstate a lapsed policy,

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generally within three years from the policy lapse. Because of the potential for anti-selection, the policy owner must provide satisfactory evidence of insurability, as well as pay any past due premiums or loans. This is an especially important protection for the life insurer whose policy death benefits can create incentive for fraud. Mandating reinstatement without any evidence of insurability, after a year has passed, opens both life and long-term care insurers to a significantly greater fraud and anti-selection risk.

Having expressed our policy concerns over Senate Bill 529 generally, we also have specific comments regarding the language and terms used in the bill:

Page 1, lines 15 and 16:

The requirements would apply to "...policies issued to residents of this state...". We would suggest that it is immaterial whether the person in question was a resident of the state when the policy was issued. The issue is whether they are a resident of the state when the policy lapses. Under the current language, a Kansas resident who buys a policy then moves out of state and lapses would be covered by the bill. On the other hand, a policy issued to a non- resident of the state who then moves to Kansas would not be covered. Some language to make the bill apply to Kansas residents whose covered policies lapse should be considered.

Page 1, line 31:

The mental incapacity of the "insured" is not the issue. It would be the mental incapacity of the policy owner that would likely cause the lapse in payments. While in many instances the policy owner and the insured might be the same person, in other circumstances they are different individuals. In cases where they are not the same person, it is the policy owner who pays the premiums. Focusing on the mental incapacity of the policy owner, not the insured, is the correct procedure. We would therefore suggest deleting the word "insured" and inserting the term "policy owner" in line 31. We would also submit this line of reasoning applies to subsequent references to the "insured" and would therefore suggest "insured" be replaced with the term "policy owner" where appropriate.

Page 1, line 32:

The one year time period is far too long. The National Association of Insurance Commissioners (NAIC) Long-Term Care Model Regulation sets a reinstatement period of five months. No time requirement is imposed on life insurance policies other than those covered by the Model LTC Regulation because they provide long-term care through acceleration of benefits. We strongly urge a shorter time period (certainly no greater than five months). If insurers are to be forced to reinstate a policy without being provided any evidence of insurability, a year's time is far large a

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window and places insurers at considerable risk. Indeed, insurers are expected to minimize risk by adhering to prudent underwriting practices based on sound actuarial principles. Senate Bill 529's requirement of reinstatement, without evidence of insurability, for up to a year seriously affects an insurer's ability to protect its other policy holders by increasing the insurer's risk.

Page 1, lines 36 - 40:

The definition of "mental incapacity" appears open to wide interpretation depending on a number of factors including the physician and individual involved. We submit this definition is overly broad and quite general. Further, Kansas already has statutory definitions at K.S.A. 59-2902 regarding persons who are mentally ill and lacking in capacity. Making judgements regarding an individual's mental condition can be an inexact science. Adding an additional level of definition for mental incapacity blurs the area further.

In addition, since under the bill the an individual would have up to a year from lapse to assert that at the time of the lapse they were suffering from a "mental incapacity" which caused the lapse, it would be possible that both the physician involved and the insurer would be dealing with a condition which occurred up to a year in the past but which was no longer present. Those in the present are asked to rely on representations regarding an individual's mental state at a specific time in the past. Again, the opportunity for fraud against an insurer is significant. Given the span of time involved and the definition offered, we believe the definition of "mental incapacity" to be inadequate.

Page 1, lines 41-42:

The current language requiring the diagnosis be rendered by a "...physician licensed in this state and qualified to make the diagnosis" requires tightening. We submit that the only physician qualified to make a "clinical diagnosis" regarding a person's mental capacity or condition, particularly if the diagnosis is being rendered about a condition which may have occurred up to a year in the past, is a board certified psychiatrist licensed in Kansas. We suggest the requirement be changed accordingly.

We further request that the insurer have be allowed to require the individual submitting a claim of mental incapacity submit to an independent medical (specifically, psychiatric) examination to protect the insurer against fraud.

Page 2, lines 2-5:

The term "insured" should be replaced with "policy owner" for the reasons described above.

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7-4

Page 2, lines 10-11:

As stated above, reinstatement under these conditions with no requirement of evidence of insurability poses too great a risk to insurers. The requirement for reinstatement under these circumstances should not be enacted. But if it is to be made law, evidence of insurability should be provided to the insurer. The term "without" should be replaced with the word "with." In the alternative, as stated above, the insurer should at a minimum be allowed to require the person asserting mental incapacity to submit to examination by an independent board certified psychiatrist to protect against fraud.

Page 2, lines 23-25:

Allowing the insurer to decline reinstatement if the mental incapacity occurred after applicable grace periods offers no protection to the insurer. Under the terms of this bill a person is seeking to show incapacity prior to the expiration of the grace period. Most insurers send notice of lapse during the grace periods mentioned. They do this to try to conserve the business and keep the policy in force. Once the grace period has expired, the condition of the insured/policy owner becomes immaterial. This provision of the bill states the obvious. The issue created by Senate bill 529 involves determining, up to a year after the fact, the mental state of the insured/policy owner prior to the expiration of the grace period.

Page 2, lines 26-36:

The disclosure provisions of the bill add additional and impractical requirements. Kansas would be only the second state in the country to pass such a law and impose such requirements. This means insurers would be required to "flag" all Kansas policies subject to the law and create a separate system for handling them when a lapse occurs. As stated above, most insurers send notice of lapse to policyholders in an attempt to conserve the business. The policy provisions regarding reinstatement and grace periods are already covered by K.S.A. 40-2203. Requiring an additional disclosure within 90 days of lapse on all existing policies covered by the bill would pose tremendous compliance difficulties for any insurer with a significant number of policies in force in the state.

Page 2, lines 41-42:

If the bill already spells out who is to receive the disclosure (lines 26-36), how many days the insurer has to send the disclosure (lines 26-36) and what type of notice constitutes compliance with the act (lines 37-39), it would seem there is little left for the insurance commissioner to decide regarding "the form and manner" of disclosure. We suggest relieving the insurance commissioner of this additional duty and deleting lines 41-42.

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Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Tom Wilder, Director of
Government and Public Affairs

Re: S.B. 529 (Reinstatement of Life Insurance
and Long Term Care Policies)

Date: February 8, 1996

The Kansas Insurance Department supports the concept behind S.B. 529 which is designed to assist life insurance and long term care insurance policyholders whose insurance may lapse because the person responsible for the payment of premiums does not make monthly payments due to mental incapacity. There are situations where an individual because of mental incapacity, such as Alzheimer Disease, may forget to pay premiums on a life insurance or long term care policy. In these cases, some provision should be made to reinstate the policy if the past due premiums are paid.

The Insurance Department suggests that Subsection (1) (a) be deleted from the bill so that the requirements would apply to life insurance or long term care policies which have a nonforfeiture benefit. These types of policies might include a provision whereby any accumulated cash value is applied to unpaid premiums. However, this type of language is not required and often policies do not include a provision for the payment of past due premiums from the accumulated cash value of the policy.

The National Association of Insurance Commissioners has developed model regulations for long term care insurance. They have included a provision to deal with the

Senate F+I
2/8/96
Attachment # 8

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unintentional lapse of policies. A copy of the NAIC rule is attached to my testimony. This language may provide another approach to the problem.

The Senate Committee should seriously consider protection for Kansas consumers who may find that coverage under their long term care insurance or life insurance policies is denied because of the unintentional non-payment of premiums. The Kansas Insurance Department supports legislation similar to that proposed in S.B. 529.

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purchase of additional coverage shall be subject to Paragraph (2) for any subsequent premium rate increases where no additional purchases of coverage are made.

(4) The commissioner may amend, for universal application, the premium rate restrictions imposed by this subsection, in appropriate circumstances, including but not limited to the following:

(a) State or federal law is amended, materially affecting the insured risk;

(b) Unforeseen changes occur in long-term care delivery, insured morbidity or insured mortality; or

(c) Judicial interpretations or rulings are rendered regarding policy benefits or benefit triggers resulting in unforeseen claim liabilities.

(5) Nothing in Paragraph (4) shall limit the commissioner's authority pursuant to other sections of the insurance code of this state.

(6) Except as provided in Paragraph (7), the provisions of this Subsection F shall apply to any long-term care policy or certificate issued in this state on or after the effective date of this amended regulation.

(7) For certificates issued on or after the effective date of this Subsection F, under a group long-term care insurance policy as defined in [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this amended Subsection F shall not apply.

Section 7. Unintentional Lapse

Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

A. (1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's *full name* and *home address*. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

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The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(2) When the policyholder or certificateholder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Subsection A(1) need not be met until sixty (60) days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to Subsection A(1), at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

B. Reinstatement. In addition to the requirement in Subsection A, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Section 8. Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

Drafting Note: The last sentence of this subsection is intended to apply to long-term care policies which are part of or combined with life insurance policies, since life insurance policies generally do not contain renewability provisions.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

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STATE OF KANSAS
BILL GRAVES
GOVERNOR

W. Newton Male
Bank Commissioner

Judi M. Stork
Deputy Commissioner

Kevin C. Glendening
Assistant Deputy Commissioner

William D. Grant, Jr.
General Counsel

Ruth E. Glover
Administrative Officer

OFFICE OF THE
STATE BANK COMMISSIONER

SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE

FEBRUARY 8, 1996

Mr. Chairman and Members of the Committee:

I am Judi Stork, Deputy Commissioner, and I am here today on behalf of Commissioner Newton Male and the Office of the State Bank Commissioner to testify for Senate Bill 571.

Senate Bill 571 amends K.S.A. 9-904, which governs the way in which a bank may reduce its capital stock. I would like to note, and it is important to remember, that this amendment in no way would reduce the total capital a bank is presently required to maintain. To explain what this amendment actually does, I'd like to talk a little about how a bank's capital is determined.

A new bank chartered today would be required to have a minimum total capital of $250,000 or 8% of its estimated deposits 5 years after its organization, whichever is greater. That sum of capital must initially be divided up so that 60% of the total represents the par value of the outstanding shares of stock, another 30% goes into the surplus account, and the remaining 10% is placed in undivided profits.

From that point forward, before paying a dividend, the bank must transfer 25% of its net profits to the surplus account until the surplus account at least equals the amount of capital stock. The purpose of this restriction is to ensure that, as the bank continues to grow in its deposit base, a portion of the bank's profits are "set aside" in the form of additions to the surplus account as a buffer against any future losses. A bank may not pay a dividend from, or otherwise reduce, its surplus without permission of the Commissioner and the Banking Board.

K.S.A. 9-904 permits an existing bank, with prior approval, to reduce its capital stock to the minimum allowed for a new bank. Senate Bill 571 makes two narrowly defined changes in this statute. First, it moves the approval process to reduce capital stock to the minimum level ($250,000 or 8% of projected deposits) from the Banking Board to the Commissioner. The second change, beginning on line 19 adds new language to permit a bank to reduce its capital stock account below that minimum level by transferring those funds to the surplus account. As the bill states, this could only be done with the prior approval of the Banking Board, based on their findings of certain safety and soundness considerations as described in (b)(1-4) beginning on line 23 of the Bill.

The department's reason for requesting this new language is that currently there is no mechanism in the statute to allow a bank which over estimates its projected five year deposit growth to make an adjustment in its capital stock account. A brief example may help to shed light on this problem.

A new bank is chartered to purchase the assets of a failed institution so that banking services will continue to be provided in the community. The new bank determines that 8% of its projected deposits at the end of 5 years would be 1 million dollars. Under current law, the bank's capital structure would be $600,000 in

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Attachment #9

capital stock, $300,000 in surplus, and $100,000 in undivided profits. If the bank's actual deposit growth is considerably less than projected, the result would be a disproportionate share of total capital held in the capital stock account. This creates a problem as the bank, by law, must transfer 25% of its profits to the surplus account until surplus at least equals the amount of the capital stock account. In this example, the bank would have to increase its surplus account by an additional 3 million dollars, in spite of the fact that the projection upon which the 3 million figure was based is overstated. The necessity to fund that additional 3 million in surplus precludes the use of those funds for stock debt servicing, expansion of the bank and its services, or any other purpose of potential benefit to the bank or its community.

This amendment addresses the issue by allowing the bank to transfer a portion of the capital stock amount to the surplus account, in order to have the surplus at least equal to the capital stock, thereby eliminating the need for additional transfers from undivided profits.

The department feels the requirements contained in the amendment, which are: 1) banking board approval based on a satisfactory finding of the safety and soundness issues described in the amendment; and, 2) the minimum floor of 8% of total deposits as defined beginning on line 25 of the bill, in combination with the existing restrictions on the surplus account contained in K.S.A. 9-912, provide adequate safeguards to protect the integrity of the bank's capital structure.

We ask for favorable consideration of this bill.

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