Approved: Jan. 21, 1998
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on January 13, 1998 in Room 529-S of the Capitol.

All members were present except:

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

Conferee attending the Meeting: Tom Wilder, Kansas Insurance Department

Others attending: See attached list

Chairman Steffes introduced Committee members and staff, thanking them all for the success of the legislative achievements of the Committee. He reiterated his position regarding involvement with Nationsbank and discussed possible insurance issues for this session. He reported on the findings of the Consensus Estimating Group regarding the substantial reduction in the privilege tax collections due to a "wild card" provision implemented by former Bank Commissioner Dunnick and continued to be authorized by current Commissioner Newton Male. This provision allows banks to form subsidiary corporations and transfer their US Treasury securities to those corporations thus decreasing or eliminating the Kansas Privilege Tax. Commissioner Male has refused to name those state banks which have taken advantage of this legal option to reduce their taxes. An Attorney General's opinion is forthcoming. The Committee will address the privilege tax matter and the make-up of the State Banking Board (majority are either practicing or retired bankers) (Attachment 1).

Dr. Wolff reviewed the current bills in the Committee. The following actions were taken:

Senator Becker moved to strike SB 47 from the Calendar as the language was incorporated in SB 204 this past year. Motion was seconded by Senator Feleciano. Motion carried.

Senator Praeger moved to strike SB 64 from the Calendar. The basic language of this bill was incorporated in SB 204 also. Motion was seconded by Senator Feleciano. Motion carried.

Senator Feleciano moved to strike SB 377 from the Calendar. Motion was seconded by Senator Praeger. Motion carried.

Senator Biggs moved to strike SB 381 from the Calendar. Motion was seconded by Senator Becker. Motion carried.

Tom Wilder, Kansas Insurance Department, presented testimony supporting bill requests for the following proposed legislation (Attachment 2):

1. Health insurance - Licensing of Medicare PSO's
2. Health insurance - Privacy of Medical Records
3. Health insurance - Maternity Benefits
4. Homeowners insurance - Cancellation/Credit Reports
5. Department operations - Salary Cap
6. Department operation - Second Assessment
7. Taxation - Medicare Supplement Taxes

Senator Feleciano moved for these requests to be introduced into legislation. Motion was seconded by Senator Brownlee. Motion carried.

Senator Steffes requested the introduction of legislation which would authorize the Board of Governor's to determine the salary of unclassified employees at the Health Care Stabilization Fund. Senator Feleciano moved for the introduction of such legislation. The motion was seconded by Senator Praeger. Motion carried.

The meeting was adjourned at 10:00 a.m. The next meeting will be held on January 14, 1998.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1/13/98

NAME	REPRESENTING
Tom Wilder	Kansas Insurance Dept
Lori Callahan	KAMMCO
[illegible]	KMC
[illegible]	KAMMCO
Richard E. Wilbur	Farmers Alliance
Bill Mitchell	" "
Janelle Wilhite	Div. of Budget
Susan Anderson	Heim + Weir
Teresa Sittenauer	HIAA
Martin Hawver	Hawver's Capitol Report
Alan Steppat	Pete McGill & Associates
Mike Astle	Community Bankers Assn
Sue Anderson	" " "
Chuck Stones	KBA
Sue Schmidt	KCUA
George Barbee	Barbee & Associates
Kathy Peterson	Peterson & Assoc
John Peterson	Nations Bank
John Hanna	AP

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-13-98

NAME	REPRESENTING
Matthew Goddard	HCBA
Pat Morris	KAIA
Brad Smoot	BCBS / AHA
Callie Dell Dutton	KS Association of Health Plans

REMARKS

CHAIRMAN DON STEFFES

FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

JANUARY 13, 1998

As you may recall, on the first day of our meeting last year, I asked each of you to introduce yourself. Also, I prepared some remarks which attempted to outline some of my thoughts concerning this new challenge for both myself and the committee members. I also disclosed my potential conflict of interest and I think it is appropriate to advise you that Jane and I still own the same number of Nationsbank shares.

Probably it is no great surprise to each of you that I again have a statement to make. The real purpose of this exercise is to force me to reflect upon the effectiveness of the committee, to consider where we have been, and where we might want to go during the current session. I have found value in reducing my thoughts and goals to paper as they can then be reviewed to determine if progress may have been made or where my failures may have occurred.

Since we all know each other much better, we will not need to dwell on that part of the exercise. Needless to say, I began the Session last year very apprehensive about my ability to chair this important committee following the leadership of the very capable Senator Dick Bond. And, since we were all strangers to each other in regard to this committee, I am sure there was a degree of apprehension by all of you. But what a

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Attachment 1
1/13/98

difference a year makes. I feel more comfortable in this position and I would guess each of you do as well. And, those of you who attend our meetings, certainly know each of us much better.

My recollection of last session is very favorable. We were exceedingly busy and carried much of the load in regard to the introduction and discussion of bills concerning both Banking and Insurance. Many bills were introduced and we worked about forty of them - some of a very complex and controversial nature. Without a doubt, we have the best committee in the Legislature. Certainly, we did not agree on all of the issues, but we worked through many of them and reached reasonable compromises. The successful work and passage of the complex Kassebaum-Kennedy legislation, Patient Protection Act, resolving the Premium Tax nightmare and including the Women's Right to Know all in one package which received almost unanimous support in both houses was one of the most memorable events of my working career.

In addition to great committee members, I am especially grateful to all of the staff, Dr. Wolff, Fred Carman, Nikki and to my intern Liza. They will all be with us for another year. Each of you make it possible for us to do what we are supposed to do - make good decisions for the public good. And you keep me out of trouble (as much as you can].

I am particularly grateful for the help that I have received from my wonderful Vice Chairman, Senator Sandy Praeger. I am also grateful for the cooperation and assistance that ranking minority member Senator Paul Feleciano has given and continues to provide. These relationships make this committee the envy of the Senate. Even though there will be some partisan differences, I think we have an excellent bi-partisan working relationship and I really appreciate the business judgment that both Senator Barone and Senator Biggs bring to the committee. In fact, all of the Senators, Republican and Democrat, bring their

particular past experiences and insights to the Committee and I hope you don't mind if I continue to call upon each of you to share your thoughts with other committee members. Thank you all for making last a year a great success and making the coming year one of enthusiastic anticipation.

One of my goals last session was the establishment of a Task Force to study the Insurance Industry to determine what could be done to help it grow and prosper in Kansas. You, the Legislature, and the Governor gave me that opportunity. I urge you to read the report Dr. Wolff sent to you about a month ago. Extra copies are available if needed. Work will need to be done on several of the Task Forces recommendations. Again, I am very grateful to Senators Praeger and Feleciano for the work they did on this committee. As you read the report, you will note that there was a high degree of cooperation among all of the parties. I want to especially thank Commissioner Sebelius for her efforts and cooperation. She selected outstanding industry representatives and they, as well as the public representatives were all active participants. As you read the report, you will note that there was a high degree of candor concerning the state of the industry and what can be done to improve it. Also, there was total lack of partisan animosity. There was a sincere desire by all parties to assist the industry and the State. This does not imply that all of the issues which we will be discussing will be easily resolved or can be resolved without differences. That is not the nature of the system but we hope that we can continue to work through these matters without rancor.

There will again be many matters concerning insurance. I hope to start immediately to hear some of the less controversial ones and then move quickly to those areas which were not discussed last year, and those many issues which I know are coming before us. Certainly, the health insurance issues are always before us and it is possible that we will be involved in the new Children's Insurance initiative coming down from

Washington. If so, Senator Praeger, a real expert at both the state and national level on these issues, will be asked to provide invaluable assistance to the committee.

Again, as was mentioned in the Task Force, we are in a cycle of de-regulation and we must guide and direct this movement. It is my personal opinion that it cannot and should not be stopped. I mentioned last year, and I still believe, that the best regulation is competition. I think we should continue moving in that direction. A key point brought up over and over by the industry members of the Task Force, was that "File and Use" in Kansas must keep pace with other states. The Commissioner has been asked to report to the Legislative Committees in 1999 concerning progress the department is making in this direction. I also believe that the informal, unpaid committee of industry representatives, regulators, economic development interests and the legislature, as suggested by the Task Force, can be a major force for change for the good of Kansas and the Insurance Industry.

But this is also the Financial Institutions Committee. We really spent most of our time last year on Insurance issues until late in the session when the matter of investments of public funds took a great deal of time. As you will recall, this matter became rather divisive and was finally resolved with a compromise which was far less than desirable by the Senate. Because of very important state account problems and other issues, it seemed best for the legislature to resolve the matter in this manner.

It was my thought that banking issues would take very little time this year as, I felt that the public funds issue should be given a year or so of experience to determine its impact upon the many public bodies. However, this all changed several months ago, when the Consensus Estimating Group reported that there was a substantial reduction in the Privilege Tax collections from the banking sector.

When this was discovered, it was also revealed that a significant number of Kansas banks had formed subsidiary corporations and transferred their U. S. Treasury securities to those corporations which either eliminated or significantly reduced their liability for the payment of the Kansas Privilege Tax. A large reduction in these tax receipts was experienced. It is unknown how far reaching this will be. This activity was authorized under the "Wild Card" provision by the previous bank commissioner and maintained by the current commissioner. National banks had this authority and therefore it became available to State Banks with this order. It is possible that we should discuss the issuance of such orders and whether the legislature should have some type of fiscal impact statement as is required with all legislation. This order had an impact of millions of dollars of state revenue each year and escaped legislative oversight.

At the time this activity was discovered, it was reported by the Banking Department that 69 state banks had established such subsidiaries and an unknown number of national banks. Since this activity not only reduces state revenues, it could negatively impact lending practices of banks by encouraging the purchase of bonds. Senator Feleciano and I determined that it was essential that this committee seek all possible information concerning this matter. It was an absolute certainty and inevitable that this matter would be of utmost importance during this session of the Legislature. As this discussion of bank taxation and lending practices unfolds, it is also inevitable that other financial institutions taxation will also come under scrutiny.

Senator Feleciano and I were greatly disappointed that the bank commissioner decided to withhold the names of the state banks who took advantage of this legal option to reduce their taxes. We were of the opinion that this is a structure issue and has nothing to do with bank examinations or safety and soundness. Since there are over 300 state chartered banks and the vast majority did not exercise this option, we thought that it is

essential that we know the size, location, lending practices and time when this activity occurred. All of the banks balance sheet and income statement information is readily available to the public Without all of the other pertinent information, it seems that the committee would have to make major policy decisions without full knowledge which does not seem to be a wise course of action.

At the same time we asked the Bank Commission for the names of the banks and other related information, a request was also presented to the Comptroller of the Currency, the regulator of National Banks for this same information. We are very pleased that they made a decision to provide the names of their banks to us.

As soon as the Bank Commission advised us of his decision, Senator Feleciano and I sent a request to the Attorney General for an opinion whether he has the authority to maintain this confidentiality. We are hopeful that we will receive a positive decision. If we do not, it may be possible that some type of legislation should be considered to open this matter to the public.

It was particularly disappointing to me to discover that while the 1997 Legislature was involved in the very contentious debate concerning the deposits of public funds and hearing of the need of Kansas banks to have these public funds for lending purposes, many Kansas banks and bankers, both state and national, were simultaneously in the process of organizing an investment subsidiary to avoid state income tax which also could reduce their incentive to loan money and increase their purchase of bonds. This would have been exceedingly valuable information to have had at that time, and there is no question in my mind that the lack of this information was of significant importance in the outcome of that issue. There is a possibility that after obtaining lending information concerning activities of banks using an investment subsidiary that the public fund issue should be revisited with

more accurate and complete information. As you may recall, there was a major concern about information which was provided by the Bank Commissioner to House members during the debate in the closing days of the session concerning the issue of public funds. It is very difficult to make sound policy decisions even with correct information and much more difficult or even impossible when the information is incorrect or lacking.

It would seem that the Committee has two goals in regard to this issue. One of them is short term. That is, to review the Privilege Tax matter as it relates to both State and National banks and to determine a fair method of taxation so that the bankers of Kansas pay their fair share of the cost of state government. Of course, the Assessment and Taxation Committee will bear the major responsibility for changes in tax law, but it would seem that the F. I. & I. Committee should provide ideas and suggestions. This can only be done if we spend some time reviewing the options available. As the entire issue of taxation of financial institutions comes under review, it is likely that Credit Unions will be brought into the discussion and also other tax issues affecting all financial institutions.

The other issue is much larger and a major policy matter. It seems to me that the occurrence of this incident brings a bigger question into the discussion. That is, whether the make-up of the State Banking Board creates perceived or actual conflicts of interest. Since it is required that the majority of the members and the Bank Commissioner be active or retired state bankers, it causes, if not actual conflicts of interest, the appearance of significant conflicts. This is similar to the debate on the historic governance of the Board of Agriculture and which was resolved by the Courts and the Legislature A similar perceived conflict of interest between the Insurance industry and its regulator was resolved at the ballot box. It is my opinion that there should be a degree of tension between the regulated and the regulator. It has been my experience that this tension exists in the state banking industry on matters of safety and soundness but may be lacking in

matters of structure and policy. Of course, the existence of the FDIC, the federal insuring agency for depositors, provides an essential dual examing body with oversight over the state banking examiners on matters of safety and soundness.

Since the availability of Credit and other banking services are of critical importance to all of the people of Kansas, it would seem appropriate that our committee begin a dialogue concerning the State Banking Board. Since this issue is of such great importance and could be very sensitive, it may be desirable to establish an interim Task Force composed of Kansas leaders from all segments of our society to recommend the type of governance they deem best for State Chartered banks. Their ideas could then be digested and developed during the 1999 Session. It would be very disappointing if the banking industry would exert its considerable influence on individual legislators to resist such an objective review. Certainly, it is possible that after such a review on this governance issue and the potential for conflicts of interest, it may be determined that the make-up of the State Banking Board, the regulator of state banks, is adequate and acceptable and needs no change. To my knowledge, this issue has not been addressed for many years. Since banking is in a state of enormous change, it would seem inappropriate to avoid this discussion and reinforce the appearance of significant conflicts of interest.

As you can see, we will have plenty to do. I feel fortunate that I continue to have good health, a high level of energy and a sincere desire to serve the people of Kansas. In addition, through very good luck, I find myself in this important position with an opportunity to serve on this committee with other dedicated Kansans who have proven their ability to work together for the common good.

Now, let us begin another productive year.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: Senate Financial Institutions
and Insurance Committee

From: Tom Wilder

Re: Bill Introductions

Date: January 13, 1998

I am appearing today to request the introduction of bills by this committee on behalf of the Kansas Insurance Department. The proposed legislation deals with health insurance, homeowners policies, premium taxes and the operations of the Department of Insurance. Copies of the bills are attached to my testimony.

(1.) Health Insurance - Licensing of Medicare PSOs - Last fall, Congress approved the 1997 Budget Reconciliation Act which allows provider sponsored organizations (groups of doctors and hospitals) to contract directly with consumers to provide Medicare services. Under current law, these services must be offered through insurance companies or health maintenance organizations. The Kansas Insurance Department is requesting authority to regulate provider sponsored organizations which are offering Medicare services.

(2.) Health Insurance - Privacy of Medical Records - The legislation is based on a model act being developed by the National Association of Insurance Commissioners. The law would require insurance companies to keep health information confidential. The data can not be released except for a valid business purpose and the marketing of health information is not permitted unless authorized by the insured. In addition, consumers are permitted access to their medical records and may correct any inaccurate information.

Senate Financial Inst. & Ins.
Attachment 2
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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.) Health Insurance - Maternity Benefits - The bill requires health insurers to inform insureds when maternity benefits are available under a policy and if such coverage can be purchased as an optional rider.

(4.) Homeowners Insurance - Cancellation/Credit Reports - The bill prohibits the cancellation or nonrenewal of a homeowners policy based on a single storm loss claim within any three year period. The legislation also prohibits homeowners insurers from using credit information as the sole underwriting criteria on a policy application.

(5.) Department Operations - Salary Cap - This bill removes the prohibition against the Insurance Department paying any employee more than the Commissioner. The legislation, which was recommended by the Insurance Task Force, would allow the agency to hire actuaries.

(6.) Department Operations - Second Assessment - The legislation removes the second tax assessment used to fund the Insurance Department above the statutory limit.

(7.) Taxation - Medicare Supplement Taxes - The bill provides a premium tax credit for carriers which have incurred losses on Medicare Supplement policies sold to disabled individuals.

(2)

DRAFT (1/8/98) Medicare PSOs

_____ Bill No. _____

AN ACT concerning health maintenance organizations; providing for the licensing and regulation of Medicare provider organizations; amending K.S.A. 40-3207, 40-3208, 40-3209, 40-3210, 40-3211, 40-3213, 40-3214, 40-3215, 40-3219, 40-3220 and 40-3221 and K.S.A. 1997 Supp. 40-3202, 40-3203, 40-3204 and 40-3225 and repealing the existing sections and also repealing K.S.A. 40-3217.

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

Section 1. K.S.A. 1997 Supp. 40-3202 is hereby amended to read as follows: 40-3202. As used in this act:

(a) "Commissioner" means the commissioner of insurance of the state of Kansas.

(b) "Basic health care services" means but is not limited to usual physician, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.

(c) "Capitated basis" means a fixed per member per month payment or percentage of premium payment wherein the provider assumes risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.

(d) "Certificate of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization <u>or the medicare provider organization</u> or by the group contract holder.

(e) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(f) "Deductible" means an amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(g) "Director" means the secretary of health and environment.

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(h) "Disability" means an injury or illness that results in a substantial physical or mental limitation in one or more major life activities such as working or independent activities of daily living that a person was able to do prior to the injury or illness.

(i) "Enrollee" means a person who has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization or the medicare provider organization for health care services.

(j) "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

(k) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

(l) "Group contract holder" means the person to which a group contract has been issued.

(m) "Health care services" means basic health care services and other services, medical equipment and supplies which may include, but are not limited to, medical, surgical and dental care; psychological, obstetrical, osteopathic, optometric, optic, podiatric, nursing, occupational therapy services, physical therapy services, chiropractic services and pharmaceutical services; health education, preventive medical, rehabilitative and home health services; inpatient and outpatient hospital services, extended care, nursing home care, convalescent institutional care, laboratory and ambulance services, appliances, drugs, medicines and supplies; and any other care, service or treatment for the prevention, control or elimination of disease, the correction of defects or the maintenance of the physical or mental well-being of human beings.

(n) "Health maintenance organization" means an organization which:

(1) Provides or otherwise makes available to enrollees health care services, including at a minimum those basic health care services which are determined by the commissioner to be generally available on an insured or prepaid basis in the geographic area served;

(2) is compensated, except for reasonable copayments, for the provisions of basic health care services to enrollees solely on a predetermined periodic rate basis;

(3) provides physician services directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians or under arrangements as an independent contractor with a physician or any group of physicians;

(4) is responsible for the availability, accessibility and quality of the health care services provided or made available.

(o) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber

(p) "Individual practice association" means a partnership, corporation, association or other legal entity which delivers or arranges for the delivery of basic health care services and which has entered into a services arrangement with persons who are licensed to practice medicine and surgery, dentistry, chiropractic, pharmacy podiatry, optometry or any other health profession and a majority of whom are licensed to practice medicine and surgery. Such an arrangement shall provide:

(1) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(2) to the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff.

(q) "Medical group" or "staff model" means a partnership, association or other group:

(1) Which is composed of the health professionals licensed to practice medicine and surgery and of such other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists as are necessary for the provision of health services for which the group is responsible;

(2) a majority of the members of which are licensed to practice medicine and surgery; and

(3) the members of which: (A) As their principal professional activity over 50% individually and as a group responsibility are engaged in the coordinated practice of their profession for a health maintenance organization; (B) pool their income and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (C) share medical and

other records and substantial portions of major equipment and of professional, technical and administrative staff; and (D) establish an arrangement whereby the enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee.

(r) "Medicare Provider Organization" means an organization which:

(1) Is a provider-sponsored organization as defined by Section 4001 of the Balanced Budget Act of 1997 (PL 105-33); and

(2) provides or otherwise makes available to enrollees basic health care services pursuant to Section 4001 of the Balanced Budget Act of 1997 (PL 105-33).

(s) ~~(r)~~ "Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.

(t) ~~(s)~~ "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations.

(u) ~~(t)~~ "Physician" means a person licensed to practice medicine and surgery under the healing arts act.

(v) ~~(u)~~ "Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this state to furnish health care services.

(w) ~~(v)~~ "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency as determined by the commissioner from the latest annual statement filed pursuant to K.S.A. 40-3220 and amendments thereto.

Section 2. K.S.A. 1997 Supp. 40-3203 is hereby amended to read as follows: 40-3203. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in subsection (n) or subsection (r) of K.S.A. 40-3202 and amendments thereto without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents;

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses, official capacity with the organization and biographical information for all of the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

(4) a sample or representative copy of any contract or agreement made or to be made between the health maintenance organization or Medicare provider organization and any class of providers and a copy of any contract made or agreement made or to be made, excluding individual employment contracts or agreements, between third party administrators, marketing consultants or persons listed in subsection (3) and the health maintenance organization or Medicare provider organization;

(5) a statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, in the case of a health maintenance organization, the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation of the facilities at which health care services will be regularly available to enrollees in the case of staff and group practices, the type and specialty of health care personnel and the number of personnel in each specialty category engaged to provide health care services in the case of staff and group practices, and a records system providing documentation of utilization rates for enrollees. In cases other than staff and group practices, the organization shall provide a list of names, addresses and telephone numbers of providers by specialty;

(6) copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

(7) the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization or Medicare provider organization;

(C) financial projections using an accrual accounting system with generally accepted accounting principles for a minimum of three years from the anticipated date of certification and on a monthly basis from the date of certification through one year. If the health maintenance organization or Medicare provider organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter. Financial projections shall include:

(i) Monthly statements of revenue and expense for the first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) a quarterly balance sheet; and

(iv) statement and justification of assumptions;

(8) a description of the procedure to be utilized by a health maintenance organization or Medicare provider organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of policy and operation of a ~~the~~ health maintenance organization;

(B) monitoring of the quality of care provided by such organization including, as a minimum, peer review; and

(C) resolving complaints and grievances initiated by enrollees;

(9) a written irrevocable consent duly executed by such applicant, if the applicant is a nonresident, appointing the commissioner as the person upon whom lawful process in any legal action against such organization on any cause of action arising in this state may be served and that such service of process shall be valid and binding in the same extent as if personal service had been had and obtained upon said nonresident in this state;

(10) a plan, in the case of group or staff practices, that will provide for maintaining a medical records system which is adequate to provide an accurate documentation of

utilization by every enrollee, such system to identify clearly, at a minimum, each patient by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy, and in all other cases, evidence that contracts with providers require that similar medical records systems be in place;

(11) evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care; and

(12) such other information as may be required by the commissioner to make the determinations required by K.S.A. 40-3204 and amendments thereto.

(13) in lieu of any of the application requirements imposed by this section on a medicare provider organization, the commissioner may accept any report or application filed by the medicare provider organization with the appropriate examining agency or official of another state or agency of the federal government.

(c) The commissioner may promulgate rules and regulations the commissioner deems necessary to the proper administration of this act to require a health maintenance organization or Medicare provider organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (b) to the commissioner prior to the effectuation of the modification or amendment or to require the health maintenance organization or Medicare provider organization to indicate the modifications to the commissioner. Any modification or amendment for which the approval of the commissioner is required shall be deemed approved unless disapproved within 30 days, except the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.

Section 3. K.S.A. 1997 Supp. 40-3204 is hereby amended to read as follows: 40-3204. (a) The commissioner shall notify any person filing an application for a certificate of authority within 60 days of such filing if such application is not complete or sufficient and the reasons therefor, or that payment of the fees required by K.S.A. 40-3213 and amendments thereto has not been made or that the commissioner is not satisfied with the sufficiency of the information supplied pursuant to the provisions of K.S.A. 40-3203 and

amendments thereto or that the organization has failed to demonstrate its ability to assure that health care services will be provided.

(b) The commissioner shall, within 60 days after the receipt of a completed application and any prescribed fees, issue a certificate of authority to any person filing such application if the commissioner finds that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) any deficiencies identified by the commissioner in the application have been corrected;

(3) the health maintenance organization or Medicare provider organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise except to the extent of reasonable requirements for copayments and/or deductibles; and

(4) in the case of a health maintenance organization, that the health maintenance organization is in compliance with K.S.A. 40-3227 and amendments thereto and in the case of a Medicare provider organization, that the Medicare provider organization is in compliance with such deposit or solvency requirements as the commissioner may establish by rule and regulation .

Section 4. K.S.A. 40-3207 is hereby amended to read as follows: 40-3207 When the commissioner has reasonable cause to believe that grounds for the denial, suspension or revocation of a certificate exists or when the commissioner levies an administrative penalty, such commissioner shall notify the health maintenance organization or Medicare provider organization in writing stating the grounds upon which the commissioner believes the certificate should be denied, suspended or revoked or the penalty levied. The applicant may, within 15 days from receipt of such notice, make written request to the commissioner for a hearing thereon. The commissioner shall hear such party or parties within 20 days after receipt of such request in accordance with the provisions of the Kansas administrative procedure act.

Upon the request of the commissioner, a representative of the secretary of health and environment who is licensed to practice medicine and surgery shall be in attendance at the

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hearing and shall participate in the proceedings. Recommendations received pursuant to this subsection may be rejected or accepted in full or in part by the commissioner. Nothing in this subsection shall be construed to limit or modify in any way the authority given by the provisions of this act to the commissioner to deny, suspend or revoke a certificate or to levy an administrative penalty in lieu of suspension or revocation.

Section 5. K.S.A. 40-3208 is hereby amended to read as follows: 40-3208. (a) The powers of a health maintenance organization or Medicare provider organization shall include but not be limited to the following:

(1) The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as are necessary in the transaction of the business of the organization;

(2) the furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

(3) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(4) the contracting with an insurance company licensed in this state, or with a hospital or medical service corporation or dental service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(5) the offering, in addition to health care services, of indemnity benefits covering out-of-area or emergency services; and

(6) receiving and accepting from governmental or private agencies payments covering all or part of the cost of the services provided or arranged for by the organization.

(b) Health maintenance organizations shall provide in their arrangements with all contracting parties and providers that if there be valid medicaid coverage, providing benefits for the same loss or condition, the medicaid coverage shall be the source of last resort of any provider payment.

Section 6. K.S.A. 1997 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of group and individual certificate of coverage contracts issued by the

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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 individual practice associations or medical 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 preexisting 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) <u>in the case of a health maintenance organization,</u> 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

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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;

(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

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

(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); and

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services.

(b) No health maintenance organization or Medicare provider 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 or Medicare provider organization for any services which have been performed under contracts between such enrollees and the health maintenance organization or Medicare provider organization. Further, any contract between a health maintenance organization or Medicare provider organization and a provider shall provide that if the health maintenance organization or Medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or Medicare provider 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 or Medicare provider organization. If there is no written contract between the health maintenance organization or Medicare provider 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 or Medicare provider organization.

(c) No group or individual certificate of coverage or contract form or amendment to an approved certificate of coverage or 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 or Medicare provider organization's method for resolving enrollee grievances.

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

Section 7. K.S.A. 40-3210 is hereby amended to read as follows: 40-3210. Any health maintenance organization or Medicare provider organization issued a certificate and otherwise in compliance with this act may enter into contracts in this state to provide an agreed upon set of health care services to enrollees or groups of enrollees in exchange for a prepaid per capita or prepaid aggregate fixed sum.

Section 8. K.S.A. 40-3211 is hereby amended to read as follows: 40-3211. (a) The commissioner may make an examination of the affairs of any health maintenance organization or Medicare provider organization and providers with whom such organization has contracts, agreements or other arrangements as often as the commissioner deems it necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

(b) At least once every three years and at such other times as the commissioner may require, a health maintenance organization or Medicare provider organization shall obtain an on-site quality of care assessment by an independent quality review organization acceptable to the commissioner for the purpose of evaluating levels of health care delivery according to industry standards as prevailing from time to time. The findings of said independent quality review organization shall be expressed by it in a written opinion relating to the general quality of care provided by the health maintenance organization or Medicare provider organization and its related contractors of health care services. Failure to obtain such quality of care assessment or the rendering of an unfavorable opinion by the independent quality review organization shall give the commissioner cause to institute action in accordance with K.S.A. 40-3205, 40-3206 or 40-3207, and amendments thereto.

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(c) Every health maintenance organization ~~and provider~~ or Medicare provider organization and any of its providers shall submit its books and records relating its operation to such examinations. Medical records of individuals and records of providers under a contract to the health maintenance organization or Medicare provider organization shall be subject to such examination, but the identity of patients shall not be disclosed in any report to the commissioner or the commissioner's agents or representatives. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of the health maintenance organization or Medicare provider organization and the principals of such providers.

(d) The fees and expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner. The fees and expenses of the commissioner shall be in accordance with K.S.A. 40-223, and amendments thereto.

(e) In lieu of such examinations, the commissioner may accept the report of an examination made by the appropriate examining agency or official of another state or agency of the federal government.

Section 9. K.S.A. 40-3213 is hereby amended to read as follows: K.S.A. 40-3213. (a) Every health maintenance organization and Medicare provider organization subject to this act shall pay to the commissioner the following fees:

(1) For filing an application for a certificate of authority, one hundred fifty dollars ($150);

(2) For filing each annual report, fifty dollars ($50);

(3) For filing an amendment to the certificate of authority, ten dollars ($10).

(b) Every health maintenance organization subject to this act which has operated for a period of three years but not more than five years shall pay annually to the commissioner at the time such organization files its annual report a privilege fee in an amount equal to one-half of one per cent (.005) per annum of the total of all premiums, subscription charges or any other term which may be used to describe the charges made by such organization to enrollees; and after operating for a period of more than five (5) years from the time of organization a health maintenance organization shall pay annually to the commissioner at the time such organization files its annual report, a privilege fee in an

amount equal to one percent (1%) per annum of the total of all premiums, subscription charges or any other term which may be used to describe the charges made by such organization to enrollees. In such computations all such organizations shall be entitled to deduct therefrom any premiums or subscription charges returned on account of cancellations and dividends returned to enrollees. If the commissioner shall determine at any time that the application of the privilege fee would cause a denial of, reduction in or elimination of federal financial assistance to the state or to any health maintenance organization subject to this act, the commissioner is hereby authorized to terminate the operation of such privilege fee.

(c) For the purpose of insuring the collection of the privilege fee provided for by subsection (b) of this section, every health maintenance organization subject to this act and required by subsection (b) of this section to pay such privilege fee shall at the time it files its annual report, as required by K.S.A. 40-3220, make a return, verified by affidavits of its chief officer or principal managing director, to the commissioner, stating the amount of all premiums, assessments and charges received by the health maintenance organization, whether in cash or notes, during the year ending on the last day of the preceding calendar year. Upon the receipt of such returns the commissioner of insurance shall verify the same and assess the fees upon such organization on the basis and at the rate provided herein and such fees shall thereupon become due and payable.

(d) Premiums or other charges received by an insurance company from the operation of a health maintenance organization subject to this act shall not be subject to any fee or tax imposed under the provisions of K.S.A. 40-252, or any amendments thereto.

(e) Fees charged under this section shall be remitted to the state treasurer for deposit in the state general revenue fund.

Section 10. K.S.A. 40-3214 is hereby amended to read as follows: 40-3214. Except as otherwise provided in this act, health maintenance organizations and Medicare provider organizations certificated under the provisions of this act shall not be subject to regulation under articles 18, 19 and 19a of chapter 40 of the Kansas Statutes Annotated or acts amendatory thereof or supplemental thereto.

Solicitation of enrollees by a duly certified health maintenance organization or Medicare provider organization or its representatives shall not be construed to be a violation of any provisions of law relating to solicitation or advertising by health professionals. A list of locations of services and a list of providers who have current agreements with the health maintenance organization or Medicare provider organization may be made available to prospective enrollees, and shall be made available to prospective enrollees upon request.

Nothing in any professional practices act of any provider shall be construed to prohibit a provider from being employed by or under contract to provide health care services for a health maintenance organization or Medicare provider organization granted a certificate of authority under the provisions of this act.

Any health maintenance organization authorized under this act shall not be deemed to be practicing any act for which a provider is licensed and shall be exempt from laws relating to the practice of any act for which a provider is licensed.

Section 11. K.S.A. 40-3215 is hereby amended to read as follows: 40-3215. The commissioner shall promulgate rules and regulations necessary to carry out the provisions of this act. ~~The commissioner shall collect and make available in a single volume all health maintenance organization rules and regulations promulgated by the commissioner.~~

Section 12. K.S.A. 40-3219 is hereby amended to read as follows: 40-3219. Nothing in this act shall prohibit any health maintenance organization or Medicare provider organization from meeting the requirements of any federal law which would authorize the health maintenance organizations to receive federal financial assistance or to enroll beneficiaries assisted by federal funds.

Section 13. K.S.A. 40-3220 is hereby amended to read as follows: 40-3220. Every health maintenance organization and Medicare provider organization authorized under this act shall annually on or before the first day of March, file a verified report with the commissioner, showing its condition on the last day of the preceding calendar year, on forms prescribed by the commissioner. Such report shall include: (a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the

preceding year and (b) such other information relating to the performance of health maintenance organizations as shall be required by the commissioner.

Section 14. K.S.A. 40-3221 is hereby amended to read as follows: 40-3221. Any person who is an officer or principal managing director of the affairs of a health maintenance organization or Medicare provider organization shall be fully and personally liable and accountable for any willful and intentional violations of the provisions of this act, by himself or by persons under his control: Provided, however, It is not intended through this legislation to modify the existing law of Kansas regarding personal or corporate liability for negligence or malpractice.

Section 15. K.S.A. 1997 Supp. 40-3225 is hereby amended to read as follows: 40-3225. (a) Any director, officer or partner of a health maintenance organization or Medicare provider organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization or Medicare provider organization.

(b) A health maintenance organization or Medicare provider organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors and partners in the amount not less than $250,000 for each health maintenance organization or Medicare provider organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations or Medicare provider organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

Section 16. K.S.A. 40-3207, 40-3208, 40-3209, 40-3210, 40-3211, 40-3213, 40-3214, 40-3215, 40-3217, 40-3219, 40-3220 and 40-3221 and K.S.A. 1997 Supp. 40-3202, 40-3203, 40-3204 and 40-3225 are hereby repealed.

Section 17. This act shall take effect and be in force from and after its publication in the Kansas Register.

(2)

_____ Bill No. _____

AN ACT concerning insurance companies; regarding the privacy of medical records, enacting the Health Information Privacy Act.

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

Section 1. This act shall be known as the Health Information Privacy Act.

Section 2. As used in this act the following terms shall apply:

(a) "Carrier" of "insurance carrier" means any corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society or other person engaged in the business of insurance or subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner including accident and sickness insurance companies, health maintenance organizations, nonprofit medical and hospital service corporations or any other entity providing a plan of health insurance, health benefits or health services.

(b) "Commissioner" means the insurance commissioner of this state.

(c) "Covered person" means a policyholder, subscriber, enrollee, beneficiary, certificate holder or other person covered by a policy, contract or agreement of insurance issued by a carrier.

(d) "Disclose" means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than to an individual who is a covered person who is the subject of the information. The term includes any subsequent release of protected health information by a person to whom the protected health information was initially disclosed.

(e) "Facility" means an institution providing health care services or a health care setting including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(f) "Health care" means:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, services, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that:

(a) affects the physical or mental condition of an individual, including individual cells or their components; or

(b) affects the structure or function of the human body or any part of the human body; or

(2) Prescribing, dispensing or furnishing to an individual, drugs or biologicals, or medical devices or health care equipment and supplies.

(h) "Health care provider" or "provider" means a health care professional or facility.

(j) "Health information" means, with respect to the individual who is the subject of the information, any information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships disclosed by the individual, a member of the individual's family, or an authorized representative of such individual, that relates to:

(1) the past, present or future physical or mental health or condition of an individual, including individual cells and their components and genetic information and the results of genetic tests;

(2) the provision of health care to an individual; or

(3) the payment for the provision of health care to an individual.

(k) "Person" means an individual, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization or any similar entity or combination of the foregoing.

(l) "Protected health information" means health information:

(1) that identifies an individual; or

(2) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(m) "Unauthorized" means a use or disclosure of protected health information made by a carrier without the authorization of the subject of that information or that is not in compliance with this act.

Section 3. (a) A carrier shall develop and implement policies, standards and procedures to protect the confidentiality, security, accuracy and integrity of health information. These procedures shall include:

(1) nondisclosure and confidentiality policies and agreements that set forth guidelines for access to and use of health information maintained by the carrier;

(2) periodic training for all employees who have access to health information requirements of this act;

(3) disciplinary measures for violations of the confidentiality procedures;

(4) identification by job title and job description of those positions within the organization whose occupants have authorization to disclose protected health information; and

(5) methods for handling; disclosing, storing and disposing of health information, including procedures for appropriate responses to court ordered legal process from a governmental entity or legal process issued by an attorney.

(b) A carrier shall:

(1) include a provision requiring compliance with the carrier's confidentiality procedures and all of the provisions of this act that address the confidentiality of health information in all its contractual arrangements with persons, who acting on behalf of or at the direction of the carrier, may collect, use or disclose protected health information;

(2) conduct random audits periodically of all persons under contract with the carrier to act on behalf of or at the direction of the carrier in a manner sufficient for the carrier to determine compliance with this act and to enforce its own policies and procedures; and

(3) monitor internal operations on an ongoing basis to determine and enforce employee compliance with the carrier's policies and procedures.

Section 4. (a) A carrier shall file its confidentiality notice, policies and procedures with the commissioner and provide upon request to a covered person, in writing and in a clear and conspicuous manner, notice of the carrier's confidentiality practices. The notice shall include:

(1) a description of a covered person's rights with respect to protected health information;

(2) the uses and disclosures of protected health information authorized under this act;

(3) the procedures for authorizing disclosures of protected health information and for revoking authorizations;

(4) the procedures established by the carrier for the exercise of a covered person's rights; and

(5) the right of a covered person to obtain a copy of the carrier's confidentiality policies and procedures.

Section 5. (a) A carrier shall, no later than twenty working days after receipt of a written request from a covered person to examine or receive a copy of the requester's health information maintained by the carrier:

(1) provide a copy of the information requested to the covered person or permit the covered person to examine the information during regular business hours;

(2) notify the covered person that the carrier does not have the information and, if known, inform the covered person of the name and address of the person who has the information requested or, if the carrier will be obtaining access to the requested information, when the information will be available to the covered person; or

(3) deny the request in whole or in part if the carrier determines any of the following:

(A) knowledge of the information would reasonably be expected to identify a confidential source who provided the information in conjunction with a lawfully conducted investigation, law enforcement investigation or court proceeding; or

(B) the information was created solely for litigation, law enforcement investigation, quality assurance or peer review purposes.

(b) If a request to examine or copy health information is denied in whole or in part under this section, the carrier shall notify the covered person of the decision in writing.

(c) If a carrier does not maintain the information in the form requested by the individual, the carrier is not required to create a new record or reformulate an existing record in order to meet the request.

(d) The carrier may charge a reasonable fee for providing the health care information requested and shall provide a detailed bill accounting for the charges. No charge shall be made for reproduction of health care information requested for the purpose of supporting

a claim, supporting an appeal or accessing any federal or state sponsored or operated health benefits program.

Section 6. (a) A covered person may request in writing that a carrier amend the covered person's health information to correct any inaccuracies as long as the amendment does not delete, erase or obliterate any of the original information.

(b) Within thirty working days after receipt of a written request from a covered person to amend health information, a carrier shall do one of the following:

(1) Amend the information as requested, amend any errors documented, or act to verify the accuracy of information identified as erroneous by the covered person; or

(2) notify the covered person that the request has been denied, the reason for the denial, and that the covered person may file a concise statement of what the covered person believes to be the correct information and the reasons why the covered person disagrees with the denial. The carrier shall retain this statement filed by the covered person in the health information.

(c) If the carrier amends the information as requested pursuant to subsection (b)(1) of this section, the carrier shall furnish the amendment to:

(1) a person specifically designated by the covered person who may have, within the preceding two years, received the recorded personal information;

(2) an organization whose primary source of personal information is insurance carriers, as long as the organization has systematically received recorded personal information from the insurance carrier within the preceding seven years. However, the amendment need not be furnished if the organization no longer maintains health information about the covered person; and

(3) any organization that furnished the health information that was amended pursuant to subsection (b)(1) of this section.

(d) If the covered person files a statement pursuant to subsection (b)(1) of this section, the insurance carrier shall:

(1) clearly identify the matter of matters in dispute and include the statement in any subsequent disclosure of the health information; and

(2) furnish the statement to the persons described in subsection (c) of this section.

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Section 7. (a) Protected health information shall not be collected, used or disclosed by a carrier expect as permitted under this act, or as otherwise permitted or required by statute or court order.

(b) A carrier shall limit the collection, use or disclosure of protected health information to the minimum amount necessary to accomplish a lawful purpose related to the business of insurance and shall restrict access to such information to only those persons needing the information to perform a lawful function. Except as provided in Section 8 of this act, a carrier may not collect, use or disclose protected health information for marketing purposes.

(c) A carrier shall create a record of all disclosures made to any person who is not an employee of the carrier. The record shall include the following:

(1) the name, address and institutional affiliation if any, of the person to whom the information is disclosed;

(2) the date and purpose of the disclosure;

(3) a description of the information disclosed; and

(4) the authorization or release form allowing the receipt or disclosure of the information.

(d) A person to whom protected health information is disclosed shall not use the information for any purpose other than the lawful purpose for which it was disclosed.

(e) The provisions of this act do not affect other laws that restrict to a greater extent the collection, use or disclosures of specific types of health information to a person other than the covered person to whom the information relates. No provision of this act shall affect any other state or federal laws that expressly permit or require the collection, use or disclosure of health information.

Section 8. (a) A carrier shall not collect, use or disclose protected health information without a valid authorization by the covered person or claimant who is the subject of the information, except as permitted by Section 9 of this act or as permitted or required by law or court order. A covered person or claimant may provide specific authorization for the collection, use or disclosure of that covered person's or claimant's protected health

information for any purpose, provided that the authorization meets the requirements of this section.

(b) A carrier shall retain a covered person's or claimant's authorization in the covered person's or claimant's record.

(c) An authorization shall be valid if it is in writing or in electronic form and contains all of the following:

(1) the identify of the individual who is the subject of the information; A description of the protected health information to be collected, used or disclosed;

(3) the name and address of the person from whom the information is to be disclosed, except that an authorization provided to a carrier to support payment of a claim or benefit may generally describe the sources from which information will be collected or to whom information will be disclosed for claim settlement or health benefit purposes and is not required to include the names and address of employees of the insurance carrier;

(4) the purpose of the authorization, including the intended use of the information, and the scope of any disclosures that may be made in carrying out the purpose for which the authorization is requested, provided those disclosures are not otherwise prohibited by law. If the purpose of the disclosure is for the marketing of services or goods, or for other commercial gain, the request for authorization for disclosure shall be made separately from any other request for authorization and shall be limited to that purpose only. The purpose of the disclosure shall appear as a separate paragraph in bold type no small than twelve point. The purpose shall be state in clear and simple terms;

(5) the signature of the covered person or claimant and the date signed, or if in electronic form, a unique identified of the covered person or claimant and the date on which the covered person or claimant authenticated the electronic authorization; and

(6) a statement that the covered person or claimant may revoke the authorization at any time, subject to the rights of any person who acted in reliance on the authorization prior to revocation.

(d) An authorization shall specify a length of time for which the authorization shall remain valid, which in not event shall be for more than twelve months, except an authorization signed for one of the following purposes;

(1) to support payment of benefits under an insurance policy, in which event the authorization shall remain valid during the entire term of the policy;

(2) to support claims for benefits or compensation, in which event the authorization shall remain valid during the pendency of the claim;

(3) to support an application for an insurance policy, a reinstatement of a policy, or a change in benefits under an existing policy, in which event the authorization shall expire in twenty-four months or whenever the application is denied, whichever occurs first, or

(4) to support or facilitate ongoing management of a chronic condition or illness or rehabilitation from injury.

(e) A covered person or claimant may revoke an authorization at any time, subject to the rights of any person who acted in reliance on the authorization prior to revocation. A revocation of an authorization shall be valid if it is in writing or in electronic and is dated and authenticated as required in subsection (c)(5) of this section. A revocation of an authorization shall be retained by the carrier in the covered person's or claimant's record.

(f) A carrier that has collected protected health information pursuant to a valid authorization in accordance with this act, may use and disclose the information to employs and any person acting on behalf or at the direction of the carrier for the performance of insurance functions such as claims adjustment and management, underwriting, loss control or reinsurance. The information shall not be used or disclosed for any purpose other than in the performance of the carrier's insurance function.

(g) An authorization to disclose protected health information pursuant to this act or a production of protected health information pursuant to a court order shall not be construed to constitute a covered person's or claimant's waiver of any other privacy right provided by other federal or state laws common law of rules of evidence.

Section 9. (a) General Rules:

(1) A carrier may disclose or use protected health information without the authorization of the covered person or claimant in the following circumstances or as otherwise permitted by law:

(A) to conduct a scientific research project provided that such project:

(i) contains adequate safeguards to assure that information in a report of the research project does not identify, directly or indirectly through reference to publicly available information, the individual subject of the information; and

(ii) does not require direct contact with the covered person or claimant who is the subject of the information unless that covered person or claimant has been notified by the carrier that contact is possible and the covered person or claimant has authorized the contact;

(B) between insurance carriers, provided that the carriers are adjusting or settling related claims, and that both are using protected health information to investigate, evaluate and settle claims pursuant to a valid authorization or court order; or

(C) to the extent necessary to investigate, evaluate, settle or obtain reinsurance for third party claims, provided that the claimant is the subject of the protected health information and the information is used for no other purpose without personal authorization or statutory permission.

(2) A carrier shall disclose protected health information in any of the following circumstances:

(A) the disclosure is to federal, state or local governmental authorities to the extent that carrier disclosing the information is required by law to report protected health information.;

(B) the disclosure is to federal, state or local governmental authorities for use only in the lawful investigation or prosecution of insurance fraud, a violation of laws relating to the provision of health or the payment for health care or a violation of this act. Information disclosed by a carrier pursuant to this paragraph may not be used in any administrative, civil or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation involves the subject of the information and arises from the provision of health care or payment for health care and related benefits.

(B) the disclosure is based on a reasonable belief that the information is needed for one of the following purposes:

(i) to identify a deceased individual;

(ii) to determine the cause and manner of death by a chief medical examines or the medical examiner's designee; or

(iii) to provide necessary protected health information about a deceased person individual who is a donor of an anatomical gift.

(D) the disclosure is to a state or federal governmental authorities for the purpose of performing a federal audit, quality assurance review or utilization review.

(E) the disclosure is pursuant to a court order issued after the court's determination that the public interest is disclosure outweighs the individual's confidentiality rights provided by other federal or state laws, rules of evidence of the common law.

(b) Rules relating to health insurance carriers:

(1) a health carrier may disclose protected health information without the authorization of the covered person in the following circumstances or as otherwise permitted by law:

(A) to a health care provider employed by the carrier who is furnishing health care to the covered person or to a referring health care provider who continues to furnish health care to the covered person if the information is necessary to provide appropriate, ongoing health care treatment, and if the disclosure has not been limited or prohibited by the covered peers;

(B) to a person acting on behalf of or at the direction of the carrier to perform insurance functions, such as risk management, quality assurance, utilization review and peer review activities, and activities that support the processing and payment of health insurance claims;

(C) to reveal a covered person's presence in a facility owned by the carrier and the covered person's general health condition, provided that the disclosure is limited to directory information, unless the covered person has restricted that disclosure or the disclosure is otherwise prohibited by law. For the purposes of this paragraph, directory information means information about the presence or general health condition of a particular covered person who is in an impatient facility or is receiving emergency health care in a health care facility. General health conditions means the covered person's general health condition or status described as "critical, " poor," "fair," "good," "excellent," or in terms that denote similar conditions; and

(D) To a person engaged in peer review, utilization review or the assessment, evaluation or investigation of the quality of health care furnished by provided pursuant to statutory or regulatory standards or the requirements of a private or public program authorized to provide for the payment of health care.

(c) A workers' compensation carrier may collect or disclose protected health information without the authorization of the individual who is the subject of the information where the information t be collected is disclosed is necessary or incidental to the performance of the workers' compensation carrier's obligations under any workers compensation or related law or contract.

(d) A reinsurance carrier may disclose protected health information without the authorization of the covered person or claimant in the following circumstances or as otherwise permitted by law:

(1) to a reinsurer for the purpose of underwriting; or

(2) to a reinsurer for the purpose of conducting claim file audits.

Section 10. A carrier shall make a good faith effort to notify the covered person or claimant who is the subject of protected health information prior to disclosure pursuant to legal process, including a court order, subpoena, subpoena duces tecum or a discovery request unless otherwise ordered by the court. A carrier or the covered person or claimant who is the subject of protected health information or both, may object to disclosure under this section by filing an objection or a request for a protective order, in the appropriate forum.

Section 11. An unauthorized collection, use or disclosure of protected health information by a carrier is prohibited and subject to the penalties set forth in K.S.A. 1997 Supp. 40-2,125. An unauthorized collection, use or disclosure includes, but is not limited to:

(a) unauthorized publication of protected health information;

(b) unauthorized collection, use or disclosure of protected health information for personal or professional gain, including unauthorized health research;

(c) unauthorized sale of protected health information;

(d) unauthorized manipulation of coded or encrypted health information that reveals protected health information;

(e) use of deception, fraud, or threat to procure authorization to collect, use or disclose protected health information; and

(f) negligent or intentional failure to comply with requirement of this act.

Section 12. Notwithstanding section 8(c)(5) of this act, a minor who may lawfully consent to health care without the consent of a parent or legal guardian may exclusively exercise rights granted under this act regarding information pertaining to the health care to which the minor has lawfully consented.

Section 13. (a) An executor or administrator of a deceased individual may exercise all the rights of the deceased individual provided by this act, subject to any written limitations or restrictions by the decedent that are included in the health information.

(b) If there is no executor or administrator, the rights of a deceased individual may be exercised by the following persons, in the following order of priority:

(1) the surviving spouse

(2) any other person authorized by law to act for the deceased individual.

Section 14. The commissioner may promulgate regulations to carry out the provisions of this act.

Section 15. This act shall take effect and be in force from and after January 1, 1999.

DRAFT (1/8/98) - Maternity Benefits Offer

_____ Bill No. _____

AN ACT concerning accident and health insurance; requiring the mandatory offer of maternity benefits; amending K.S.A. 1997 Supp. 40-2,102 and repealing the existing section.

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

Section 1. K.S.A. 1997 Supp. 40-2,102 is hereby amended to read as follows: 40-2,105 (a)(1) All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state which provides coverage for a family member of the enrollee, insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a: (A) Newly born child of the enrollee, insured or subscriber from the moment of birth; (B) newly born child adopted by the enrollee, insured or subscriber from the moment of birth if a petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed within 31 days of the birth of the child; or (C) child adopted by the enrollee, insured or subscriber from the date the petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed; or (D) child placed in enrollee, insured or subscriber's home by a child placement agency as defined by K.S.A. 65-503 and amendments thereto, for the purpose of adoption from the date of placement as certified by the enrollee, insured or subscriber. In no case shall the time from the date of placement to the date the petition for adoption as provided in K.S.A. 59-2128 and amendments thereto was filed exceed 280 days.

(2) The coverage for newly born children shall consist of: (A) Coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and (B) routine and necessary immunizations for all newly born children of the insured or subscriber. For purposes of this paragraph "routine and necessary immunizations" shall consist of at least five doses of vaccine against diphtheria, pertussis, tetanus; at least four doses of vaccine against polio and Haemophilus B (Hib);

and three doses of vaccine against Hepatitis B; two doses of vaccine against measles, mumps and rubella; one dose of vaccine against varicella and such other vaccines and dosages as may be prescribed by the secretary of health and environment. The required benefits shall apply to immunizations administered to each newly born child from birth to 72 months of age and shall not be subject to any deductible, copayment or coinsurance requirements.

(3) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child or the filing of the petition for adoption or certification that a child has been placed in the home for adoption as defined by subsection (a)(1)(D) and payment of the required premium or fees must be furnished to the health maintenance organization, insurer or nonprofit service or indemnity corporation within 31 days after the date of birth or the filing of the petition for adoption or certification that a child has been placed in the home for adoption as defined by subsection (a)(1)(D) in order to have the coverage continue beyond such 31-day period.

(4) The contract issued by a health maintenance organization may provide that the benefits required pursuant to this subsection shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

(b)(1) All individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a profit or nonprofit corporation and all contracts issued by health maintenance organizations organized or authorized to transact business in this state which provides coverage for a family member of the enrollee, insured or subscriber, as to such family members' coverage, shall also offer ~~an option whereby the health insurance benefits shall include~~ if not already provided, an option whereby the health insurance benefits shall include maternity coverage for an insured or enrollee and delivery and obstetrical expenses at birth of the birth mother of a child adopted within 90 days of birth of such child by the enrollee, insured or subscriber subject to the same limitations contained in such policy or contract applicable to the enrollee, insured or subscriber. Such offer of an option

regarding such maternity and such delivery and obstetrical expense shall be made to the enrollee of a health maintenance organization and to the insured and, to the individual subscribers in the case of a group health insurance policy.

(2) Contracts issued by a health maintenance organization may provide that the benefits required pursuant to paragraph (1) of this subsection, shall be covered benefits only if the services are rendered by a provider who is designated by and affiliated with the health maintenance organization.

Section 2. K.S.A. 1997 Supp. 40-2,102 is hereby repealed.

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

DRAFT (Homeowners Policies) - 1/13/98

_____ Bill No. _____

AN ACT concerning property insurance; cancellation or decision to deny renewal of coverage.

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

Section 1. After the effective date of this act, an insurance company shall not cancel or nonrenew a policy of homeowners insurance because the insured has filed a single claim for loss due to windstorm, hailstorm or any other act of nature within any three consecutive years such policy is in force.

Section 2. After the effective date of this act, an insurance company shall not refuse to issue or renew coverage or limit the amount of coverage or charge higher rates on a policy of homeowners insurance based solely upon the insurer's knowledge of the applicant's credit history.

Section 3. As used in this act, the following terms shall apply:

(a) the term "homeowners insurance" shall mean an insurance policy insuring against the physical loss of or damage to real or personal property used for habitation and personal purposes in connection with insurance coverage offered on a one to four family dwelling or its contents.

(b) the term "credit history" shall mean information concerning the applicant's or insured's debt payment practices, delinquencies, payment history, insolvency, bankruptcy or any form of default.

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

DRAFT (12/1/97) Insurance Department Salaries

_____ Bill No. _____

AN ACT concerning employees of the Department of Insurance; regarding salaries, amending K.S.A. 40-110 and repealing the existing section.

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

Section 1. K.S.A. 40-110 is hereby amended to read as follows: 40-110. The commissioner of insurance is hereby authorized to appoint an assistant commissioner of insurance, actuaries, two (2) special attorneys who shall have been regularly admitted to practice, an executive secretary, policy examiners, two (2) field representatives, and a secretary to the commissioner. Such appointees shall each receive an annual salary to be determined by the commissioner of insurance, within the limits of available appropriations, ~~but in no case shall each annual salary exceed the salary of the commissioner of insurance as established by law~~. The commissioner of insurance ~~He~~ is also authorized to appoint, within the provisions of the civil service law, and available appropriations, such other employees as shall be necessary to administer the provisions of this act. The field representatives authorized by this section may be empowered to conduct inquiries, investigations, or to receive complaints: Provided, however, That such field representatives shall not be empowered to make, or direct to be made, an examination of the affairs and financial conditions of any insurance company in the process of organization, or applying for admission or doing business in this state.

The appointees herein provided for shall take proper official oath and shall be in no way interested, except as policyholders, in any insurance company. In the absence of the commissioner of insurance the assistant commissioner shall perform the duties of the commissioner of insurance, but shall in all cases execute papers in the name of the commissioner of insurance, by himself as assistant. The commissioner of insurance shall be responsible for all acts of an official nature done and performed by his assistant or any person employed in his office. All the appointees authorized by this section shall hold their office at the will and pleasure of the commissioner of insurance.

Section 2. K.S.A. 40-110 is hereby repealed.

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

DRAFT (12/1/97) "Second Assessment"

_____ Bill No. _____

AN ACT concerning the Insurance Department fee fund, amending K.S.A. 1997 Supp. 40-112 and repealing the existing section.

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

Section 1. K.S.A. 1997 Supp. 40-112 is hereby amended to read as follows: 40-112. (a) For the purpose of maintaining the insurance department and the payment of expenses incident thereto, there is hereby established the insurance department service regulation fund in the state treasury which shall be administered by the commissioner of insurance. All expenditures from the insurance department service regulation fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner of insurance or by a person or persons designated by the commissioner.

(b) On and after the effective date of this act, all fees received by the commissioner of insurance pursuant to any statute and the portion of taxes received pursuant to K.S.A. 40-252 and amendments thereto, which is certified by the commissioner of insurance to be necessary for the purposes of the insurance department service regulation fund ~~and which, together with the total amount of fees deposited to the credit of the insurance department service regulation fund pursuant to this subsection, does not total more than $4,800,000 for any fiscal year,~~ shall be remitted to the state treasurer for deposit in the state treasury and credited to the insurance department service regulation fund. ~~The total amount credited to the insurance department service regulation fund pursuant to this subsection for any fiscal year shall not exceed $4,800,000.~~

~~(c) Except as otherwise provided by this section, the commissioner of insurance shall make an annual assessment for the fiscal year ending June 30, 1993, and for each fiscal year thereafter, on each group of affiliated insurers whose certificates of authority to do business in this state are in good standing at the time of the assessment. The total amount of all such assessments for a fiscal year shall be equal to the amount sufficient which, when combined with the total amount to be credited to the insurance department service regulation fund pursuant to subsection (b) is equal to the amount approved by the~~

~~legislature to fund the insurance company regulation program. With respect to each group of affiliated insurers, such assessment shall be in proportion to the amount of total assets of the group of affiliated insurers as reported to the commissioner of insurance pursuant to K.S.A. 40-225 and amendments thereto for the immediately preceding calendar year, shall not be less than $500 and shall not be more than the amount equal to .0000015 of the amount of total assets of the group of affiliated insurers or $25,000, whichever is less. The total assessment for any fiscal year after the fiscal year ending June 30, 1993, shall not increase by any amount greater than 15% of the total budget approved by the legislature to fund the insurance company regulation program for the fiscal year immediately preceding the fiscal year for which the assessment is made. In the event the total amount of the assessment would be less than the aggregate amount resulting by assessing the $500 minimum on each insurer, the commissioner may establish a lower minimum to be assessed equally on each insurer.~~

~~(d) Assessments payable under this section shall be past due if not paid to the insurance department within 45 days of the billing date of such assessment. A penalty equal to 10% of the amount assessed shall be imposed upon any past due payment and the total amount of the assessment and penalty shall bear interest at the rate of 1.5% per month or any portion thereof.~~

(c) ~~(e)~~ On or after July 1, 1992, when there exists in the insurance department service regulation fund a deficiency which would render such fund temporarily insufficient during any fiscal year to meet the insurance department's funding requirements, the commissioner of insurance shall certify the amount of the insufficiency. Upon receipt of any such certification, the director of accounts and reports shall transfer an amount of moneys equal to the amount so certified from the state general fund to the insurance department service regulation fund. On June 30 of any fiscal year during which an amount or amounts are certified and transferred under this subsection, the director of accounts and reports shall provide for the repayment of the amounts so transferred and shall transfer the amount equal to the total of all such amounts transferred during the fiscal year from the insurance department service regulation fund to the state general fund.

(d) ~~(f)~~ Any unexpended balance in the insurance department service regulation fund at the close of a fiscal year shall remain credited to the insurance department service regulation fund for use in the succeeding fiscal year and shall be used to reduce future assessments or to accommodate cash flow demands on the fund.

(e) ~~(g)~~ The commissioner of insurance shall exempt the assessment of any insurer which, as of December 31 of the calendar year preceding the assessment, has a surplus of less than two times the minimum amount of surplus required for a certificate of authority on and after May 1, 1994, and which is subject to the premium tax liability imposed on insurers organized under the laws of this state. The commissioner of insurance may also exempt or defer, in whole or in part, the assessment of any other insurer if, in the opinion of the commissioner of insurance, immediate payment of the total assessment would be detrimental to the solvency of the insurer.

(f) ~~(h)~~ As used in this section:

(1) "Affiliates" or "affiliated" has the meaning ascribed by K.S.A. 40-3302 and amendments thereto;

(2) "group" or "group of affiliated insurers" means the affiliated insurers of a group and also includes an individual, unaffiliated insurer; and

(3) "insurer" means any insurance company, as defined by K.S.A. 40-201 and amendments thereto, any fraternal benefit society, as defined by K.S.A. 40-738 and amendments thereto, any reciprocal or interinsurance exchange under K.S.A. 40-1601 through 40-1614 and amendments thereto, any mutual insurance company organized to provide health care provider liability insurance under K.S.A. 40-12A01 through 40-12A09 and amendments thereto, any nonprofit dental service corporation under K.S.A. 40-19A01 through 40-19A14 and amendments thereto, any nonprofit medical and hospital service corporation under K.S.A. 40-19C01 through 40-19C11 and amendments thereto, any health maintenance organization, as defined by K.S.A. 40-3202 and amendments thereto, or any captive insurance company, as defined by K.S.A. 40-4301 and amendments thereto, which is authorized to do business in Kansas.

Section 2. K.S.A. 1997 Supp. 40-112 is hereby repealed.

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

DRAFT (Premium Tax/Medicare Supplement Policies) - 1/13/98

_____ Bill No. _____

AN ACT concerning insurance premium taxes; providing for tax credits for policies sold to individuals who purchased Medicare supplement policies prior to April 28, 1996 who were eligible to purchase such insurance because of a disability.

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

Section 1. (a) On and after January 1, 2000, the premiums which an issuer of a Medicare supplement policy as defined in K.S.A. 40-2221 and amendments thereto, may charge for a Medicare supplement policy issued to a person eligible for Medicare by reason of disability prior to April 28, 1996 shall not exceed the premium charged by such issuer for a policy containing the same benefits issued to a person age 65 who is eligible for Medicare by reason of age.

(b) On or before July 1, 1998, issuers of Medicare supplement coverage to persons eligible for Medicare by reason of disability having policyholders who acquired such coverage prior to April 28, 1996 shall submit to the commissioner of insurance a plan by which such issuer shall so adjust its rates that the rates charged as of January 1, 2000, shall comply with the provisions of subsection (a). Such plan shall provide for a reduction of such rates in an amount no less than one-half of the amount needed to bring such rates into compliance with subsection (a) in 1999. The commissioner shall approve or disapprove such plan based upon meeting the standards set forth herein. In the event of disapproval by the commissioner of such rates, the issuer shall be entitled to notice and hearing pursuant to the provisions of the administrative procedures act as applied to actions of the commissioner of insurance.

Section 2. An issuer of Medicare supplement policies which issued such policies without underwriting to persons eligible for Medicare by reason of disability prior to April 28, 1996, shall be entitled to a credit against premium taxes otherwise owing under K.S.A. 40-252 and amendments thereto to the extent of the difference between the actual claims and administrative expense incurred by such issuer for such coverage and the rates actually charged by such issuer. In order to claim such credit, the issuer shall provide with its

annual premium tax return an actuarial statement prepared by an independent consulting actuary setting forth the method of derivation of such difference. The issuer shall be entitled to such credit for premiums charged commencing April 28, 1996. Such issuer may claim the premium tax credit in the amount of such differences for 1996, 1997 and 1998 starting with premium taxes due for 1998, and may claim such premium tax credits for premiums charged in years subsequent to 1998 in the premium tax return for the year for which such premium tax is due.

Section 3. This act shall take effect and be in force from and after its publication in the Kansas Register.