Approved: _____
Date

MINUTES OF THE HOUSE COMMITTEE ON INSURANCE.

The meeting was called to order by Chairperson Bob Tomlinson at 3:30 p.m. on March 23, 1999 in Room 527-S of the Capitol.

All members were present except:	Rep. Burroughs, Phelps
Committee staff present:	Bill Wolff, Research Ken Wilke, Revisor Mary Best, Secretary
Conferees appearing before the committee:	Linda DeCoursey-Kansas Insurance Department Brad Smoot-Blue Cross/Blue Shield Brenda Eldridge-Topeka Independent Living Resource Center Bill Sneed-Health Insurance Association of America
Others attending:	See Attached Guest List

The Chair addressed the committee and conferees and promptly opened the public hearings on **SB 291**.

SB 291: Medical Insurance Supplement Policies

Linda DeCoursey, Kansas Insurance Department, gave Proponent Testimony to the Committee. Copies of the testimony and supplement are (Attachment #1 & 2) attached hereto and incorporated into the Minutes by reference. Ms. DeCoursey appeared in support of the bill which would act as a mechanism, to pay excess cost of the disabled who are under 65, and qualify for Medicare by their health condition. There is no federal mandate opening an enrollment period for people who are eligible for Medicare because of a medical disability. The only people addressed through legislation are the ones who reach 65 and become eligible for Medicare this way. There are at the present, 15 states which have enacted regulations to ensure those Medicare beneficiaries, ill and disabled, had the opportunity to acquire supplemental policies to fit their needs, in the marketplace. Kansas to date is not one of these states. "The Insurance Department supports the amendments made to SB 291 in the Senate, which extends the risk-sharing mechanism prospectively, so that these excess costs don't fall exclusively on older Kansans." A copy of page 6 of the bill (Attachment #2) is enclosed.

Questions were asked by Representatives Boston, Kirk and Chairman Tomlinson

Mr. Brad Smoot, Blue Cross Blue Shield of Kansas, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #3) attached hereto and incorporated into the Minutes by reference. Mr. Smoot stated his client company sells supplemental Medicare policies in Kansas. They were the one of only a few companies issuing policies without underwriting. SB 291 does not involve tax money and makes sure no one company is covering ALL of the elderly. This bill will attempt to spread the coverage among other companies.

Questions were asked by Representatives Kirk and Myers

Brenda Eldridge, Topeka Independent Living Resource Center, gave Proponent Testimony to the committee. A copy of the testimony is (Attachment #4) attached hereto and incorporated into the Minutes by reference. Ms. Eldridge stated the Independent Living Center was in support of the bill. There were no questions.

Mr. Bill Sneed, Health Insurance Association of America, offered Proponent Testimony to the committee. A copy of the testimony is (Attachment #5) attached hereto and incorporated into the Minutes by reference. They "concur that changes need to be made, and therefore support SB 291, which they feel adequately addresses most of those concerns." There were no questions.

With no further discussion of conferee testimony, the public hearings on the bill were closed.

The Chair then asked the committee for their attention while the worked **SB 3, 121, 291, 151 & 152.**

SB 291: Medicare insurance supplement policies

A call for motion was made and Rep. Kirk moved to adopt the balloon. Rep Toelkes seconded the motion. Discussion by Rep. Boston. Rep. Kirk moved to pass the bill out as amended. Rep. Toelkes seconded the motion. Motion passes.

SB 121: Insurance rate filings

Motion was called for on this bill. Rep. Cox moved to pass the bill out favorably. Rep. O'Brien seconded the motion. There was no discussion. Motion passes.

SB 3: Providing coverage for general anesthesia and medical care facility charges for certain dental care.

Discussion to consider combining **SB 3 & SB 14,** as one bill and placing with **HB 2005**. The Balloon (Attachment #6) combines **SB 3 & SB 14**, and amend into This will amend **HB 2005** and provide different language to be considered. It restores "1 year" and eliminates some of the original language on page 3 and merely indicates mandate of such coverage should be applied to state health care benefits program. Another purpose is to cut down the amount of information the Department of Administration would have to provide. It would also clear up other language where there were problems when it was in the House Committee earlier. **Rep. Kirk made the motion to accept the Balloon to combine SB 3 and SB 14 into HB 2005 and to amend the bill. Motion seconded by Rep. Empson.** Discussion with Rep. Boston, responded to by Rep. Kirk. Discussion by Rep. Cox. Revisor Wilke explains the statutes and section 5 of the bill along with other provisions. Rep. Myers requested and received clarification. Committee moved back to the motion. **Motion to adopt the balloon passes. Rep. Kirk made a motion to pass out the bill marked favorable for passage. Rep. Toelkes seconded the motion. Short discussion with Rep. Grant. Motion carries.**

SB 151: Kansas Viatical Settlements Act

An Amendment was proposed by Kansas Department of Insurance, Rep. Cox made the motion to adopt the Balloon (Attachment #7), Rep. Showalter seconds. No discussion, motion passes. Rep. Humerickhouse moves to pass the bill out favorably as amended. Motion is seconded by Rep. Jenkins. No discussion. Motion carries.

SB 152: Insurance licensing requirements for insurance agents; continuing education

Rep Grant moves to adopt the Balloon (Attachment #8). Rep. Cox seconds the motion. No discussion. Motion passes. Rep. Grant moves to pass out favorably as amended. Rep. Showalter seconds the motion. No discussion. Motion passes.

Meeting was adjourned. Time 4:25 p.m.

HOUSE INSURANCE COMMITTEE GUEST LIST

DATE: March 23, 1999

NAME	REPRESENTING
Brad Smoot	BCBS
Bill Sneed	HIAA
Dave Hanson	Ks Insur Assns
Larrie Ann Brow	KAHP
Brenda Eldridge	Public Policy Advocate Topeka Independent Living Resource Center
Mike Shultz	Federico Consulting
Linda McCoursey	KS Insurance Dept.
Paul Davis	Kansas Insurance Dept.
KEVIN ROBERTSON	KS DENTAL ASSN.
Stacy Soldan	Stein & Klein Chtd

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: House Committee on Insurance

FROM: Linda De Coursey

RE: SB 291 – Medicare Supplement Disability – creating a reinsurance program

DATE: March 23, 1999

Mr. Chairman and members of the Committee:

I am appearing in support of SB 291 which would create a mechanism, through the high risk pool, to pay the excess costs of the disabled Kansans who are under-65 years old, and qualify for Medicare by virtue of their health condition. There are approximately 3,300 Kansans who share similar characteristics with the policyholders of the Kansas Health Insurance Association plan; they are considerably sicker than the average Kansan.

When Congress passed the legislation which revised federally regulated Medicare supplemental insurance (October 31, 1994 – H. R. 5252), the law did not mandate an open enrollment period for those individuals who become eligible for Medicare because of a medical disability. The Congressional legislation only addressed those Americans who reached age 65 and became eligible for Medicare. In spite of Congressional oversight, by 1996, there were 15 states which enacted regulations to make sure that those Medicare beneficiaries, who were ill and disabled, had an opportunity to buy supplemental policies in the marketplace. Kansas was not one of the states with a guaranteed issue, and, in fact, most of the companies who sold Medicare

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House Comm on Ins.
Attachment #1
March 23, 1999

Supplemental insurance in Kansas either refused to underwrite these policyholders or charged such extremely high rates that the policies were unaffordable.

After receiving dozens of anguished pleas from Kansas consumers, and following several meetings with insurers in the marketplace, Commissioner Sebelius implemented a new policy for the sale of Medicare Supplemental insurance policies in Kansas. While she was willing to take the issue to the Legislature, the insurers urged that the policy be enacted by regulation, and not by statute. Kansas Insurance Department Bulletin 1996-4 was issued (it is attached), and companies selling Medicare supplemental insurance in Kansas were required to offer supplemental insurance plans to medically-disabled Kansans, when they became Medicare-eligible, and charge age-65 rates.

While that took care of the problem prospectively, there were approximately 4,000 Kansans, who were already Medicare eligible, who had either very high priced Medicare Supplemental policies, or were refused the sale of a policy, or priced entirely out of the marketplace.

The 1996 proposal included an enrollment period for six months in 1996, advertisements about the new opportunity for Medicare-eligible disabled Kansans to purchase a supplemental insurance policy, and a plan to phase-down the rates of current policyholders on a graduated scale, until they reached age-65 rates by the year 2000.

In 1996, Blue Cross and Blue Shield of Kansas had the bulk of the policyholders, because they were one of the only companies voluntarily offering supplemental insurance to disabled Kansans. Consequently, the company has experienced major losses due to the higher claims experience, and the agreement to phase down the rate differential. This issue was discussed with the Legislature last year, and the bill suggested that the company be given a premium tax credit for these additional losses. For a variety of reasons, that bill was not successful.

The Insurance Department supports the creation of a mechanism to spread the risk evenly and fairly among insurers. By developing a reinsurance and assessment mechanism, which would be administered by the KHIA board, with administrative costs paid by the companies selling Medicare supplement insurance, we can accomplish that purpose.

The bill, as originally drafted, only applies to those disabled Kansans who became Medicare eligible prior to 1996, and, by virtue of their ill health, this is a dwindling population. The losses in excess of 65%, (the loss ratio allowed by Congress for this business), would be tabulated each year and allocated back to those providers in the marketplace based on a market-share formula.

It is a mechanism which makes sure that older Kansans don't bear the entire cost of this positive public policy for medically-disabled Kansans; that the costs are shared by all companies doing business in the Medicare supplemental marketplace.

Kansas Health Insurance Association (KHIA) was originally established by the Legislature to provide comprehensive health insurance for those Kansans who had serious pre-existing health conditions. Creation of the risk pool allowed the excess claims costs to be shared by companies in the marketplace, and ultimately to be shared by taxpayers through premium tax credits. What the Legislature recognized was that those buying health insurance shouldn't bear the excess costs of those Kansans who had serious illnesses.

The disabled, under-65 Medicare population has the same high health claims as the current KHIA policyholders. Now their excess losses are paid only by those over-65 year old Kansans who purchase Medicare supplemental insurance. Higher costs could drive some older Kansans out of the marketplace. This bill creates a risk-sharing arrangement, so the excess costs are spread among all the companies selling Medicare supplemental insurance in the marketplace, similar to the companies which currently are assessed for excess health costs by KHIA.

SB 291, as originally drafted, only provided risk-sharing for excess losses of disabled Kansans who became Medicare eligible prior to 1996, because that is the initial problem we were seeking to address. But as it was pointed out in Senate committee hearings, the rate disparity is ongoing. The Insurance Department can support the amendments made to SB 291 in the Senate, which extends the risk-sharing mechanism prospectively, so that these excess costs don't fall exclusively on older Kansans.

I would be pleased to respond to any questions or inquiries about this proposal.

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Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

Bulletin 1996-4

TO: All Insurance Companies authorized to transact Medicare Supplement Insurance Business in the State of Kansas

FROM: Kathleen Sebelius
Commissioner of Insurance

SUBJECT: Revisions to the Kansas Medicare Supplement Regulation K.A.R. 40-4-35

DATE: April 29, 1996

The Kansas Insurance Department sent a copy of the captioned revisions to you on April 9, 1996, which enumerated the various areas where changes would occur. The hearing for the proposal was held on Wednesday, April 17, 1996, during which testimony was heard. After considering testimony, no changes were made to alter the content of the proposed regulation. The proposed regulation became effective April 28, 1996, to meet the deadline specified by the Health Care Financing Administration (HCFA).

The purpose of this bulletin is to provide additional information which will assist you in complying with the 1995 Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act and its revisions. All individual and group Medicare supplement plans issued or delivered in Kansas must comply with the requirements of the revised K.A.R. 40-4-35 as of its effective date.

K.A.R. 40-4-35, as revised, includes several technical corrections made to the Medicare Supplement Model Regulation by the Health Care Financing Committee as required by the Social Security Act Amendments of 1994 (SSAA-94). The following additional changes were made by the Kansas Insurance Department to K.A.R. 40-4-35.

- Disabled individuals under the age of 65 who became eligible for Medicare Part B prior to the effective date of this regulation receive a six-month open enrollment period beginning April 28, 1996. Such disabled individuals may purchase, during this six-month period, any standardized Medicare supplement plan offered by a Medicare supplement issuer.

- Disabled individuals under the age of 65 who become eligible for Medicare Part B after the effective date of this regulation receive a six-month open enrollment period beginning the first day of the first month the applicant becomes eligible for Medicare. Such disabled individuals may purchase any standardized Medicare supplement plan offered by a Medicare supplement issuer.

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- Premium rates charged to disabled individuals who became eligible for Medicare Part B prior to the effective date of this regulation shall not exceed 150% of the premium rate charged to Medicare supplement insureds who are age 80 for such plan.

- Premium rates charged to disabled individuals who became eligible for Medicare Part B after the effective date of this regulation shall not exceed those rates charged to Medicare supplement insureds age 65 for such plan.

Section 14(C)(2) of the 1995 NAIC Medicare Supplement Model has been amended by deleting subsection (d) --"The offering of coverage to individuals eligible for Medicare by reason of disability," and allowing up to "three (3) additional policy forms or certificate forms of the same standard Medicare supplement benefit plan, one for each of the following cases:." Such changes were necessary as a result of the amendments to Section 11(A). Due to these revisions, a Medicare supplement issuer shall not offer, after the effective date of this regulation a separate, distinct disability policy or certificate. Each disabled applicant shall be offered the same plan an applicant who is eligible for Medicare by reason of age is offered, making a separate disabled policy or certificate unnecessary.

Section 17 of the 1991 NAIC Medicare Supplement Model has been amended to incorporate changes which were made to provide sufficient information to follow the SSAA-94 revisions to the anti-duplication provisions of OBRA 1990. These changes were made to both the Statements and Questions sections. Specifically, changes were made concerning Medicaid eligibility in order to determine whether an applicant is a Qualified Medicare Beneficiary (QMB) or a Specified Low-Income Medicare Beneficiary (SLMB).

Section 10 of the 1995 NAIC Medicare Supplement Model has been adopted by the Kansas Insurance Department. This adoption provides the regulation needed to allow companies wishing to offer Medicare SELECT policies and/or certificates in Kansas to do so.

To comply with the aforementioned revisions to K.A.R. 40-4-35, it will be necessary make the necessary revisions to the application and rates you currently have approved. The following changes shall be made expeditiously to the aforementioned forms:

- Each Medicare supplement application needs to be amended to facilitate the determination of Medicaid eligibility (i.e. whether an applicant is a QMB or a SLMB).

- A revised premium rate schedule addendum for your Medicare supplement policies and/or certificates should be submitted incorporating those rates to be charged to disabled Medicare beneficiaries. The appropriate rates to be charged to disabled Medicare supplement insureds under the age of 65 shall be charged as of the effective date of the regulation. Those insurers currently charging disabled Medicare supplement insureds a rate less than 150% of the age 80 rate shall charge those rates currently on file with the Kansas Insurance Department. The crediting and/or refunding of premium shall be made for those current disabled Medicare beneficiaries under the age of 65 who have paid premium for any period after April 28, 1996, including April 28, 29, and 30. For those companies that, prior to the effective date of this

regulation, provided disabled Medicare supplement coverage to insureds, it will be necessary to provide us with detailed information including the number of disabled insureds receiving refunds and the method used by companies to credit or refund premiums paid for any period after the effective date.

Another issue to bring to your attention involves the enactment of 1996 Substitute for Senate Bill No. 529 to become effective July 1, 1996. Senate Bill No. 529 amends K.S.A. 40-2221a requiring Medicare supplement issuers to reinstate any Medicare supplement policy in the event of lapse if the issuer is provided proof of cognitive impairment or the loss of functional capacity within five months after termination and the insured requests such reinstatement. The standard used to determine proof of impairment shall be established by clinical diagnosis by a person licensed to practice medicine and surgery and qualified to make such determination.

It is imperative that your company notify your agents certified by your company to write Medicare supplement business in Kansas of these changes. In addition, it is of importance for your company to notify those individuals working internally of these revisions to K.A.R. 40-4-35 and K.S.A. 40-2221a, including but not limited to the marketing personnel, underwriting personnel, and claims personnel. The aforementioned changes must be made by your company to comply with K.A.R. 40-4-35 as soon as possible. The Kansas Insurance Department will expedite the review of forms and rates submitted to comply with the revisions.

If you should have questions concerning K.A.R. 40-4-35 as revised, you may contact the Accident and Health Division of this Department.

Kathleen Sebelius
Kansas Insurance Commissioner

KS:gcj
Enclosure

K.A.R. 40-4-35. Medicare supplement policies; minimum standards; requirements. Sections 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 24 and appendices A, ~~and~~ B, and C of the national association of insurance commissioners' "model regulation to implement the national association of insurance commissioners' medicare supplement insurance minimum standards model act," ~~July 1991~~ April 1995 edition, are hereby adopted by reference, subject to the following additions or exceptions:

(a) Section 3 is hereby amended to read as follows: "B. This regulation shall not apply to:

"(1) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; and

"(2) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the ~~such~~ group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation."

(b) Section 3 is hereby amended by the addition of subsection C., which ~~reads~~ shall read: "This regulation shall supersede any other Kansas administrative regulation to the extent the regulation or any provision of it is inconsistent with or contrary to this regulation."

(c) Section 7(A)(3) is hereby amended to read as follows: "Each ~~A~~ medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Subject to the requirements of section 14B of this regulation or any applicable statutory requirements, premiums may be modified to correspond with such changes."

(d) Section 7(B)(2) is hereby amended to read as follows: "Coverage for all of the medicare part A inpatient hospital deductible amount."

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(e) Section 8(A)(3) is hereby amended to read as follows: "Each ~~A~~ medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and co-payment percentage factors. Subject to the requirements of section 14B of this regulation or any applicable statutory requirements, premiums may be modified to correspond with such changes."

(f) Section 11(A) is hereby amended to read as follows: "An issuer shall not deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and enrolled for benefits under medicare part B, or becomes enrolled for benefits under medicare part B without regard to age. An issuer shall not deny coverage to an applicant under 65 years of age who enrolled for benefits under medicare part B prior to the effective date of this regulation when the applicant applies for coverage during the six-month period beginning with the effective date of this regulation. Each medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subsection without regard to age."

(g) Section 14(B) is hereby amended to read as follows: "An issuer shall not use or charge premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. An issuer shall not charge individuals who become eligible for medicare by reason of disability after the effective date of this regulation, and who are under the age of 65, premium rates for any medicare supplement insurance benefit plan offered by the issuer that exceed the issuer's premium rates charged for such plan to individuals who are age 65 or older. An issuer shall not charge those individuals who became eligible for medicare by reason of disability prior to the effective date of this

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regulation, and who are under the age of 65, premium rates for any medicare supplement insurance benefit plan offered by the issuer that exceed 150% of the rate charged for such plan to medicare supplement insureds who are age 80."

(h) Section 14(C)(2) is hereby amended to read as follows: "With the approval of the commissioner, any issuer may offer up to three additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan. One additional form may be offered for each of the following cases:

"(a) The inclusion of new or innovative benefits;

"(b) The addition of either direct response or agent marketing methods; or

"(c) The addition of either guaranteed issue or underwritten coverage."

~~(f) Section 15C is hereby amended to read as follows: "No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced."~~

~~(g)~~ (i) Section 16(A)(5) is hereby amended to read as follows: "Medicare supplement policies or certificates shall have a notice prominently printed on or attached to the first page of the policy or certificate ~~or attached thereto~~ stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the insurer in a timely manner. The ~~Such~~ notice shall be printed in not less that 10-point type and shall be printed in bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy."

~~(h)~~ (j) Section 16(C) is hereby amended by the addition of the following:

"(5) A description of policy provisions relating to renewability, cancellation, or continuation of coverage, including any reservation of rights to change premium.

"(6) The amount of premium for this policy. The premiums for the policy or certificate shall be shown separately from the premiums for any optional or supplemental riders.

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"(7) The name and address of the insurance agent, or the employee of the insurer who assumes responsibility for completing the outline."

~~(i)~~ (k) Section 17(E) is hereby amended by the deletion of paragraphs (1) and (2), ~~(applicable~~ relating to preexisting conditions~~)~~, in their entirety.

~~(j)~~ (l) Section 17(F) is hereby amended to read as follows: "If a medicare supplement policy or certificate of insurance issued for delivery in this state replaces an existing medicare supplement policy, regardless of the company issuing the policy, the insurer issuing the new policy, in applying any preexisting conditions provisions, waiting periods, elimination periods, and probationary periods, shall make available by rider or otherwise, coverage which provides credit for the satisfaction or partial satisfaction of the same or ~~smaller~~ similar provisions under a previously existing plan."

~~(k)~~ (m) Section 22 is hereby amended to read as follows: "A. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate to the extent such time was spent under the original policy.

"B. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods."

~~(l)~~ (n) This regulation shall become effective ~~April 1, 1992 or 45 days following its publication in the Kansas Register, whichever is later~~ April 28, 1996. (Authorized by K.S.A. 40-103, 40-2221; implementing K.S.A. 40-2221; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; effective, T-40-12-16-88, Dec. 16, 1988; amended, T-40-3-31-89, March 31, 1989; amended June 5, 1989; amended Oct. 15, 1990; amended April 1, 1992; amended P-_____.)

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Disabled Kansas Under Age 65 Covered by Medicare Supplement Insurance			
# of Disabled Covered in Kansas	**Company**	**Statewide Premium Total through 1997**	**Total # of Lives Covered in Kansas**
1,945	Blue Cross Blue Shield of Kansas, Inc.	$155,734,944	132,924
0*	Prudential Insurance Company of America	$27,872,037	22,800
207	Bankers Life and Casualty Company	$18,039,694	12,813
132	Blue Cross and Blue Shield of Kansas City	$10,266,209	5,877
1	United American Insurance Company	$6,855,985	4,867
24	Federal Home Life Insurance Company	$3,724,787	3,294
17	American Republic Insurance Company	$3,017,236	2,867
81	Physicians Mutual Insurance Company	$2,799,630	2,730
5	Union Bankers Insurance Company	$2,681,071	1,624
42	Mennonite Mutual Aid Association	$2,645,658	2,364
110	Principal Mutual Life Insurance Company	$2,308,859	1,272
6	Standard Life and Accident Insurance Company	$2,270,968	1,462
10	Reserve National Insurance Company	$2,261,737	2,194
50	Pioneer Life Insurance Company	$2,253,855	1,950
13	Hartford Life Insurance Company	$2,062,662	2,438
29	Mutual Of Omaha Insurance Company	$1,928,375	1,403
35	Continental General Insurance Company	$1,673,923	1,640
50	American Family Mutual Insurance Company	$1,007,085	923
10	Aid Association for Lutherans	$868,980	542
229	Order of United Commercial Travelers of America	$835,953	1,281
4	Humana Health Plan Inc	$674,478	451

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

1-12
~~12-19~~

8	Mutual Protective Insurance Company	$534,365	619
6	Combined Insurance Company of America	$534,110	485
1	Pyramid Life Insurance Company	$522,534	326
	Time Insurance Company	$452,558	760
26	Central States Health and Life Company of Omaha	$444,662	458
	Fortis Insurance Company	$434,527	732
	Allianz Life Insurance Company of North America	$410,365	545
6	American Family Life Assurance Company of Comumbus	$381,309	284
0	Golden Rule Insurance Company	$377,926	248
0	American General Life Insurance Company	$365,644	244
7	Monumental Life Insurance Company	$308,149	205
2	USAA Life Insurance Company	$305,620	361
1	Life Investors Insurance Company of America	$245,061	285
12	Life Insurance Company of Georgia	$234,746	135
6	National Foundation life Insurance Company	$180,327	105
0	New York Life Insurance Company	$168,257	123
	Globe Life and Accident Insurance Company	$131,346	125
2	Provident Life and Accident Insurance Company	$127,674	N/A
3	World Insurance Company	$126,325	104
3	Guarantee Trust Life Insurance Company	$107,840	159
	Atlas Insurance Company	$95,656	95
	Allied Life Insurance Company	$93,672	112
2	Bankers United Life Assurance Company	$84,952	84
0	Harvest Life Insurance Company	$60,268	78

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

1-13
~~13-14~~

0	Union Labor Life Insurance Company	$41,529	36
0	United Teacher Associates Insurance Company	$33,834	18
0	Healthy Alliance Life Insurance Company	$30,910	29
8	Medico Life Insurance Company	$27,262	29
0	Providian Life and Health Insurance Company	$24,255	15
8	Humana Insurance Company	$23,342	31
	Celtic Life Insurance Company	$22,492	19
2	PFL Life Insurance Company	$20,032	16
0	Academy Life Insurance Company	$15,565	14
	Union Fidelity Life Insurance	$14,680	17
0	Bankers Multiple Line Insurance Company	$14,610	9
0	Hartford Life and Accident Insurance Company	$9,215	9
	National Travelers Life Company	$8,265	4
0	Colonial Life and Accident Insurance Company	$3,393	8
2	Central Benefits National Life Insurance Company	$3,351	3
	American Travellers Life Insurance Company	$3,084	2
0	National Helath Insurance Company	$2,795	10
3	Lincoln National Life Insurance Company	$2,171	3
0	Bankers Fidelity Life Insurance Company	$0	0
0	Continental Life and Accident Company	$0	0
0	Health and Life Insurance Company of America	$0	0
159	United Healthcare Insurance Company	N/A	N/A
Total		**Total**	**Total**
3,267		**$258,812,804**	214,660

*Prudential lost AARP Business to United Healthcare Insurance Company in 1997, affecting group business.

made against the plan and the expenses of operating the plan. In following years, rates for coverage shall be reasonable in terms of the benefits provided, the risk experience and expenses of providing the coverage, except that such rates shall not exceed 150% of the average premium rate charged for similar coverage in the private market. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex and geographic location in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices, however particular health conditions or illnesses shall not constitute appropriate risk factors;

(5) assess members of the association in accordance with the provisions of K.S.A. 40-2121, and amendments thereto;

(6) design the policies of insurance to be offered by the plan which shall cover at least the expenses enumerated in subsection (b) of K.S.A. 40-2123, and amendments thereto, but with such limitations and optional benefit levels as the plan prescribes;

(7) issue policies of insurance in accordance with the requirements of this act; and

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

(d) The association shall administer a reinsurance program for medicare supplement policies issued to Kansas residents who are eligible for medicare by reason of disability ~~*prior to April 28, 1996*~~*. All medicare supplement insurers* ***issuing or*** *renewing medicare supplement policies in this state* ~~*sold prior to April 28, 1996,*~~ *shall be participants in such reinsurance program. (1) On or before May 1, 2000, and each year thereafter, each issuer of a medicare supplement policy in the state shall provide to the association a calendar year accounting of the medicare supplement policies delivered or issued for delivery in the state* ***[prior to April 28, 1996,]*** *and covering persons eligible for medicare by reason of disability who are under age 65. (2) The accounting for medicare supplement policies covering persons eligible by reason of disability and under age 65 shall include the total number of such persons covered, the total premium earned on such persons, and the total claims expense incurred with respect to such persons during such year as paid through March 31, without estimates for incurred but not reported claims. (3) The association shall use such reports to develop the assessment required under subsection (d) of K.S.A. 1998 Supp. 40-2121, and amendments thereto.*

Sec. 3. K.S.A. 1998 Supp. 40-2121 is hereby amended to read as follows: 40-2121. (a) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the plan expenses of

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BRAD SMOOT

ATTORNEY AT LAW

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
To
House Insurance Committee
Regarding 1999 SB 291
March 23, 1999

Blue Cross Blue Shield of Kansas is a not for profit mutual life insurance company providing insurance benefits to 700,000 Kansans in 103 counties. We actively sell Medicare supplement policies to tens of thousands of Kansans and for more than thirty years we have sold policies to the disabled who qualify for Medicare. We very much appreciate the Insurance Commissioner's introduction of SB 291 and are pleased to offer our support.

Prior to the effective date of the Kansas Insurance Department's regulation requiring open enrollment for Medigap policies, we were one of only a few companies which issued polices to the disabled without underwriting (meaning we did not exclude applicants based on health). As you would suspect, persons who qualify for Medicare by reason of disability rather than age often suffer serious, debilitating illnesses and are frequent users of health care services. As a group, these Kansans will always cost far more to serve than they will ever contribute in premium.

While Blue Cross Blue Shield of Kansas has a substantial portion of the Medicare supplement business in Kansas, prior to 1996 we attracted virtually all the disabled Medicare business. In 1996, the KID decided to reduce the disabled premium contribution for new enrollees to the age 65 rate (the lowest in the Medicare Supp business) and 120% of the age 80 rate for existing enrollees. The latest KID regulation will drop all disabled premiums to the lowest MediGap rates available. With its disproportionate share of high risk, high cost disableds, BCBS's elderly policyholders will further subsidize the disabled.

Last year, the Insurance Department proposed, and we supported, a bill to allow premium tax credits (just as we now do for the high risk pool assessments) for losses suffered by our Medicare pool of insureds (1998 SB 457). Because the bill would have passed all the cost of such losses on to the state general fund, the Senate was less than enthused about SB 457. SB 291 takes a totally different approach by creating a reinsurance mechanism within the high risk pool (Kansas Health Insurance Association) which shares the losses among the carriers who are obliged by law to shoulder the burden of the Medicare disabled. No state tax dollars are involved.

As introduced, SB 291 only addressed the historical problem of BCBS's willingness to "do the right thing" before it was required by law. However, all carriers continue to face the possibility of acquiring a disproportionate share of disabled insureds. Consequently, the Senate Committee amendments, applying the reinsurance mechanism prospectively, are a necessary and appropriate response to a real marketplace distortion that requires correction. We believe SB 291, as amended, will encourage more carriers to market Medigap policies to the disabled in Kansas while spreading the risk more evenly. We urge your support.

Thank you for your interest in our views.

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Offices located in
the Historic Crawford Building

Topeka Independent Living Resource Center

785-233-4572 V/TDD • Fax 785-233-1561 • Toll Free 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

Testimony to the House Insurance Committee

Regarding Senate Bill 291

Presented By; Brenda L. Eldridge, L.B.S.W., Public Policy Advocate

Topeka's Independent Living Resource Center, (TILRC), lends its support to Senate Bill 291. For those individuals that this bill would provide reinsurance for, this bill implements existing law in a meaningful way because its impact presents a "win-win" situation for all parties involved. The bill effectively addresses critical situations such as;

1.) Those individuals that have exhausted their COBRA Insurance and choose to go without care due to high end, out-of-pocket costs precipitated by the inherent structure of having to wait for two years for Medicare eligibility and increase long term health consequence and greater costs overall.

2.) Individuals that do choose to get care are presently left with the option of ineffective, inefficient emergency care services. The greater cost of these services are then passed on to the surrounding community of tax payers and various other community inputs.

3.) The remaining choice for individuals is that of immediate impoverishment. With impoverishment care is immediately available through poverty programs such as Medicaid coverage.

The logic behind the present choices, that this bill will correct, seems oddly backwards when our goal is to provide effective treatment, avoidance of high cost and long term consequence and complications. Another aspect of the existing situation is that it inadvertently punishes those that contribute to the economy through wage taxes and input and yet, conversely, if impoverished, immediate coverage is available. This bill effectively covers a worker's time frame gap between COBRA and Medicare eligibility, and thereby lessens the long term effects of inadequate or non-existent coverage.

Thank you for your time, efforts and thoughtful considerations, if there re questions I would gladly answer them at this time. TILRC asks the committee to support the adoption of Senate Bill 291 into a meaningful piece of legislation. For questions or concerns, please feel free to contact Mike Oxford, Executive Director or myself at (785) 233-4572.

Advocacy and services provided by and for people with disabilities.

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MEMORANDUM

TO: The Honorable Bob Tomlinson, Chairman
House Insurance Committee

FROM: Bill Sneed, Legislative Counsel
Health Insurance Association of America

DATE: March 23, 1999

RE: S.B. 291

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am here today representing the Health Insurance Association of America ("HIAA"). HIAA is the nation's leading advocate for the private, market-based health care system. Our 255+ members provide health insurance to approximately 110 million Americans. We appreciate this opportunity to provide comments on S.B. 291. After reviewing the bill, we concur that changes need to be made, and we believe that S.B. 291 adequately addresses most of those concerns, and we respectfully request that the Committee pass this bill out favorably.

BACKGROUND

It is our understanding that prior to 1996, Blue Cross/Blue Shield of Kansas had voluntarily issued Medicare supplement policies to the disabled and had a large block of disabled policyholders. The practice of Blue Cross/Blue Shield was to charge this block of disabled policyholders according to the claims experience of the group, which means they paid a higher premium than other Medicare supplement policyholders.

In 1996, the Kansas Insurance Department held a public hearing on a proposed regulation dealing with this issue. This regulation would require insurance companies to issue Medicare supplement policies to people who are eligible for Medicare because of their disability.

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+3

The regulation would also require that the group of disabled Medicare recipients would not be charged any different rate than the other non-disabled Medicare recipients. At the time of the public hearing on this regulation, HIAA stated its opposition to the implementation of the regulation. We argued that, as a group, the disabled are far sicker than people who become eligible for Medicare at age 65. Many of them suffer from end-stage renal disease and would not be eligible for insurance from most insurance companies. Because the disabled are sicker than the over-65 category of Medicare supplement policyholders, they also cost far more to insure.

Notwithstanding our objections, the Insurance Department adopted the regulation in 1996. In its implementation, the Department permitted Blue Cross/Blue Shield of Kansas to continue to charge its existing block of disabled policyholders more than the over-65 category. However, the regulation did require Blue Cross/Blue Shield and all other insurers to charge new Medicare disabled policyholders the same rate as the over-65 category. The regulation also required that Blue Cross/Blue Shield phase in equal rates for all Medicare supplement policyholders, so that by the year 2000 Blue Cross/Blue Shield could no longer charge disabled and over-65 Medicare supplement policyholders different premiums.

DISCUSSION

Because insurers can no longer charge a rate equal to the risk that the disabled category represents, it has incurred substantial losses on its pre-1996 business. Thus, insurers end up with a disproportionate share of Medicare disabled policyholders. As long as insurers can not charge a premium corresponding to the higher risks of the disabled, these losses will continue to mount. As long as the higher risks and resulting losses are spread unevenly among insurers, competitive pressures will prevent insurers with more disabled policyholders from charging their Medicare supplement policyholders an adequate premium. Without a long term solution, the losses

will increase, insurers will leave the market, and all Medicare beneficiaries will find they have fewer choices and higher costs in the Medicare supplement policies.

PROPOSED SOLUTION

As we understand S.B. 291, it is an attempt to encompass the pre-1996 and post-1996 block of policyholders. We believe that such a global solution will better serve the Medicare beneficiaries in the Kansas market. The risk-sharing mechanism provides a broad-based, long-term solution that is fair to all participants. Thus, we contend that S.B. 291 should be acted on favorably.

We appreciate the opportunity to present this testimony, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W. Sneed

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As Amended by Senate Committee

Session of 1999

SENATE BILL No. 3

By Special Committee on Financial Institutions and Insurance

12-15

AN ACT relating to accident and health insurance; providing coverage for general anesthesia and medical care facility charges for certain dental care; amending K.S.A. 1998 Supp. 40-2,103 and 40-19c09 and repealing the existing sections; also repealing K.S.A. 1998 Supp. 40-1909.

providing coverage for reconstructive breast surgery; providing requirements for mandated coverages;

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

New Section 1. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, also, shall provide coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:

(1) A child ~~eight~~ ***five*** years of age and under; or

(2) a person who is severely disabled; ~~and~~ ***or***

(3) ~~such~~ ***a*** person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

(b) A policy, provision, contract, plan or agreement may:

(1) Apply to the covered procedures under this section the same deductibles, coinsurance, ***network requirements*** and other limitations, ***including but not limited to medical necessity determinations,*** as apply to other covered services;

(2) require prior authorization for hospitalization for the covered procedures under this section in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(c) The provisions of this section shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined by K.S.A. 40-2227, and amendments thereto, medicare supplement, as defined by the commissioner of insurance by rules and regulations, vision care or other limited-benefit supplemental insurance, nor any coverage issued as a supplement to liability

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insurance, workers' compensation or similar insurance, automobile medical-payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(d) Nothing herein shall be construed to require any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, fraternal benefit society or health maintenance organization to provide benefits for any dental procedures.

(e) The provisions of this section shall apply to the state health care benefits program and municipal self-funded pools.

(f) As used in this section "medical care facility" shall have the meaning ascribed to the term in K.S.A. 65-425, and amendments thereto.

Sec. 2. K.S.A. 1998 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1998 Supp. 40-2,160, *and amendments thereto, and section 1* shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 3. K.S.A. 1998 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1998 Supp. 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 ~~and~~, 40-2,164 *and section 1*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

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

(c) Violation of subsection (b) shall be subject to the penalties pre-

New Section 1. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, and which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Such coverage shall be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

(b) Each individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services which provides medical and surgical benefits with respect to a mastectomy shall provide written notice, as currently required, to all enrollees, insureds or subscribers regarding the coverage required by this section.

(c) No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services which provides medical and surgical benefits with respect to a mastectomy shall:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit[,] dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227 and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as

scribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 4. K.S.A. 1998 Supp. 40-2,103, 40-1909 and 40-19c09 are hereby repealed.

Sec. 5. This act shall take effect and be in force from and after its publication in the statute book.

defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

Section 5. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year ~~and six months~~ **beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature.** ~~At the end of such time period,~~ the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, ~~on the day the governor's budget report is submitted to the legislature,~~ a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should ~~be authorized by the legislature to apply to~~ the state health care benefits program ~~and to all individual or group health insurance policies, medical service plans, contracts, hospital service corporation contracts, hospital and medical service corporation contracts, fraternal benefit societies or health maintenance organizations which provide coverage for accident and health services~~.

(b) The legislature shall periodically review all ~~current and any future mandated~~ health insurance coverages.

[On or before March 1, after the one year period for which the mandate has been applied,]

[continue for]

[or whether additional utilization and cost data is required]

[mandated by state law]

(2) the ~~issues~~ ***issuer*** of a life insurance policy providing accelerated benefits under K.S.A. 40-401, and amendments thereto, and pursuant to the contract; or

(3) a natural person who enters into no more than one agreement in a calendar year for the transfer of [like] insurance policies for any value less than the expected death benefits. [life

(i) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a catastrophic, life threatening or chronic illness or condition who enters or seeks to enter into a viatical settlement contract.

(j) "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

Sec. 3. (a) A person shall not operate as a viatical settlement provider, viatical settlement representative or a viatical settlement broker without first having obtained a license from the commissioner.

(b) Application for a viatical settlement provider, viatical settlement representative or viatical settlement broker license shall be made to the commissioner by the applicant on a form prescribed by the commissioner. Each application shall be accompanied by a nonrefundable fee of $1,000.

(c) Any license issued pursuant to this section shall expire on the anniversary of its date of issuance unless the licensee pays the renewal fee. Any license issued pursuant to this section may be renewed from year to year on the anniversary of the date of issuance upon payment of the annual renewal fee of $500. Failure to pay the fee by the renewal date results in expiration of the license.

(d) The applicant shall provide information on forms required by the commissioner. The commissioner shall have the authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees, and the commissioner, in the exercise of the commissioner's discretion, may refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards of this act.

(e) A license issued to a legal entity authorizes all members, officers and designated employees to act as viatical settlement providers, viatical settlement brokers or viatical settlement representatives, as applicable, under the license, and all those persons shall be named in the application and any supplements to the application.

(f) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and issue a license if the commissioner finds that the applicant:

(1) Has provided a detailed plan of operation;

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examination, shall receive credit for the C.E.C.'s assigned by the commissioner or commissioner's designee as recognition for the approved subject. No other credit shall be given for independent study.

(i) The commissioner may waive the continuing education requirements imposed by this act for nonresident agents who provide evidence of compliance with continuing education requirements imposed by their state of domicile.

Sec. 3. K.S.A. 1998 Supp. 40-241 is hereby amended to read as follows: 40-241. Any applicant or prospective applicant for an agent's license, if an individual, shall be given an examination by the commissioner or the commissioner's designee to determine whether such applicant possesses the competence and knowledge of the kinds of insurance and transactions under the license applied for, or to be applied for, of the duties and responsibilities of such a license and of the pertinent provisions of the laws of this state. The applicant shall be tested on each class or subclassification of insurance which may be written. An examination fee prescribed in rules and regulations adopted by the commissioner shall be paid by the applicant and shall be required for each class of insurance for each attempt to pass the examination. Such examination fee shall be in addition to the certification fee required under K.S.A. 40-252, and amendments thereto. There shall be four classes of insurance for the purposes of this act:

(1) Life;

(2) accident and health;

(3) casualty and allied lines; and

(4) property and allied lines.

~~A limited~~ **An** *insurance ~~representative~~ license may be issued as a subclassification of casualty and allied lines to any auto rental agency ~~or employee of that agency~~. An auto rental agency may offer or sell insurance only in connection with and incidental to the rental of motor vehicles, whether at the rental office, at the point of delivery of a vehicle, or by preselection of coverage in a master, corporate or group rental agreement, in any of the following general categories: (1) Personal accident insurance covering risks of travel, (2) motor vehicle liability insurance,* ***[with or without the sale of uninsured, underinsured motorist coverage]*** *(3) personal effects insurance providing coverage to renters and other occupants of the motor vehicle, (4) roadside assistance and emergency sickness protection programs, and (5) any other travel or auto-related coverage an auto rental company may offer in connection with and incidental to rental of motor vehicles. No insurance may be issued by a ~~limited insurance representative~~* ***an auto rental agency*** *unless the rental period of the rental agreement does not exceed 90 consecutive days and brochures and other written material clearly and correctly explaining insurance cov-*

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