Approved: _____
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE .

The meeting was called to order by Chairperson Senator Don Steffes at 1:00 p.m. on March 31, 1999, in Room 521 S of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Research
Ken Wilke, Office of Revisor
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Susan Olander, General Counsel, Federated Rural Electric Insurance
Linda DeCoursey, Kansas Department
Kathleen Sebelius, Insurance Commissioner
Jerry Slaughter, Kansas Medical Society
Steve Montgomery, United Health Care of the Midwest

Others attending: See Attached

Hearing and action on SB 356 - Establishing a procedure for the conversion of a stock or mutual insurance company into an insurance reciprocal

Susan Olander, General Counsel for the Federated Rural Electric Insurance Corporation, Lenexa, explained to the Committee that they were a property and casualty insurance company insuring rural electric and rural telephone cooperatives across the country (Attachment 1). She related the history of their formation in Wisconsin as a stock insurance company. In order to take advantage of certain provisions in the federal tax code, Federated is interested in converting to a reciprocal exchange. Wisconsin does not offer this option but Kansas statutes allow a stock insurance company to merge into a reciprocal exchange. This would apply to them if approval of statutory language in Kansas is added which would clarify that a stock insurance company may "convert" to a reciprocal exchange. They have been headquartered in Kansas for more than 15 years.

Linda DeCoursey, Kansas Insurance Department, appeared in support of the bill which would update a 1927 statute (Attachment 2). A reciprocal or inter-insurance exchange is a legal agreement between a number of persons or companies, in which they all agree to insure or indemnify each other against losses. Mrs. DeCoursey said KID was interested in helping the company accomplish redomesticating and converting from a stock to a reciprocal company in a one-step, seamless transaction. She said the adoption of the proposed statutes would allow others to use this method of corporate governance and make Kansas more insurance friendly.

Senator Becker moved to add an amendment to make the bill effective upon publishing in the Kansas Register and to report the bill favorably as amended. Motion was seconded by Senator Praeger. Motion carried.

Discussion on SB 80 - External review

Kathleen Sebelius, Insurance Commissioner, presented both agreed upon changes for Substitute for **SB 80** and points of contention between the Kansas Insurance Department and the industry (Attachment 3). A copy of the proposed substitute bill which is crafted after the NAIC model was included in the attachment. During discussion, the Kansas Medical Society stated they would agree to the point stating in law that the insured's treating physician or provider complete a written opinion that the treatment is medically necessary. Commissioner Sebelius stated that their goals was to put in place a quick, timely procedure for medical decisions primarily for persons involved in an HMO.

Jerry Slaughter, Kansas Medical Society, stated they had met several times and were willing to continue working on the bill.

Steve Montgomery, United Health Care of the Midwest, stated they have implemented external review on their own. Within their process, a statute of limitations has been established somewhere between two and three years due to medical contracts being changed, treatment programs changing, and personnel changes.

Also the review board must rely on the doctor go give his/her opinion on whether the treatment is medically necessary as well as different standards are necessary for experimental and new treatment levels.

Three balloon amendments were submitted by the industry addressing the bullet points reviewed by Commissioner Sebelius (Attachment 4):

- Legislature to determine the scope of the review and the requirements of the review determination, rather than delegating to the Commissioner through rules and regulations
- Legitimizing the review process which would be binding on both parties (exceptions listed).
- Limiting external review to one/year on the same set of facts; and to either, but not both, state or federal review processes.

The Committee questioned the need for the development of a new model for external review when 16 states already have the process in place. Would the adoption of such an external review process as proposed into a potentially litigious process? Is the language presented by the industry clear and definite enough to avoid misunderstanding in seeking an external review i.e., "preponderance of medical and scientific evidence?"

The meeting was adjourned at 2:00 p.m.

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST
DATE: March 31, 1999

NAME	REPRESENTING
Pat Morris	
Jerry Humphrey	
Jolene Brobst	
Bill Sneed	
Lee Knight	
Dana Lawrence	
Jon Bills	
Burgess	
Stuart L Lowry	
Susan Olander	
Jerry Slaughter	
Dave Hanson	
Lori Calhoun	
Stacey Salle	
Lassie Ann Brown	
John Federico	
Steve Montgomery	
Danielle Rae	
Paul ~~Evans~~ Davis	

Application (WordPerfect; "WordPerfect"; Default!; "EN")
FontSize (FontSize: 13.98p)
AttributeAppearanceToggle (Attrib: Bold!)

SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
GUEST LIST

DATE: _____

NAME	REPRESENTING
Maggie Kolling	
Kathleen Scheibus	
Cheryl Fillard	
Linda DeCoursey	
John Peterson	
Brad Sagat	
Gerard Grenaldi	
Anne Haught- KID	

Application (WordPerfect; "WordPerfect"; Default!; "EN")
FontSize (FontSize: 13.98p)
AttributeAppearanceToggle (Attrib: Bold!)

Federated RURAL ELECTRIC INSURANCE CORP.

1959 1999

Memorandum

TO: Chairman Don Steffes
Senate Committee for Financial Institutions & Insurance

FROM: Phil Irwin, Vice President – Finance and Chief Financial Officer
Susan M. Olander, General Counsel

DATE: March 26, 1999

SUBJECT: Federated Rural Electric Insurance Corp.

Federated Rural Electric Insurance Corp. (the "Company") is a commercial property and casualty insurance company insuring rural electric and rural telephone cooperatives across the country. Currently, the Company is domesticated in the State of Wisconsin, where it began operation in 1959. Federated was originally formed to provide workers' compensation insurance for the rural electric cooperatives in Wisconsin. From this limited concept, the Company grew and expanded into all lines of commercial property and casualty insurance and is currently authorized to write business in forty-one (41) states. Of those forty-one states, the Company actively writes in all but Alaska, Florida and Texas. The Company has been licensed in Kansas since 1962 and writes full coverage for all but two of the rural electric cooperatives located within the state.

Due to insurance laws in place in the State of Wisconsin at the time, Federated was organized as a stock insurance company. In order to more accurately reflect its heritage and the nature of its insureds as well as to take advantage of certain provisions in the federal tax code, Federated has explored the potential for converting the stock corporation into a reciprocal exchange.

As the Company is domiciled in Wisconsin, this idea was initially explored with the Office of the Insurance Commissioner in the State of Wisconsin. Wisconsin does not have the necessary statutory language to allow a reciprocal exchange to be domiciled in Wisconsin. Therefore, as the Company is located primarily in Lenexa, Kansas, officers with the Company began a dialogue with the Kansas Insurance Commissioner. Current Kansas statutes allow a stock insurance company to merge into a reciprocal exchange.

Senate Financial Institutions & Insurance
Date 3/31/99
Attachment # 1

P.O. Box 15147, Lenexa, KS 66285-5147 ■ 11875 W. 85th Street, Lenexa, KS 66214-1519
(800) 356-8360 ■ (913) 541-0150 ■ Fax: (913) 541-9004 ■ www.federatedrural.com

Memorandum
To: Chairman Don Steffes
Senate Committee for Financial Institutions & Insurance
From: Susan M. Olander, General Counsel
Federated Rural Electric Insurance Corp.
Page Two
March 26, 1999

Discussions have been held with the Insurance Commissioner's office, and verbal authorization to proceed with a redomestication to the State of Kansas and a merger into a reciprocal exchange have been given.

In examining all of the tax aspects of this transaction, the Company noted the necessity of qualifying the transaction as to tax-free reorganization so as to avoid a corporate-level tax on the transaction. In order to help comply with the intent of the definition set forth in Internal Revenue Code Section 368(a)(1)(E), which requires a "recapitalization" of an existing corporation, the change in the Company's legal structure should be viewed as a conversion transaction in which the reciprocal exchange is a continuation of the stock insurance company. It should be noted that the conversion will in no way annul, modify or change any of the insurer's existing suits, rights, contracts or liabilities except as provided in the plan filed with and approved by the commissioner of insurance. Therefore, Federated is requesting the introduction and approval of statutory language in the State of Kansas which would clarify that a stock insurance company may "convert" to a reciprocal exchange. Current statutes allow a merger or acquisition, but are silent as to a "conversion."

If the Company can qualify the transaction as a tax-free reorganization, the Company would realize significant tax savings for fiscal year 1999. These tax savings would flow through to the insureds of the Company. Currently, approximately 5 percent of the Company's premiums are generated by insureds located in the State of Kansas.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Financial Institutions & Insurance

FROM: Linda De Coursey

RE: SB 356 -- Establishing a procedure for the conversion of a stock or mutual insurance company into an insurance reciprocal.

Mr. Chairman and members of the Committee:

Thank you for the opportunity to discuss SB 356 with you. I am appearing today in support of SB 356. Recently, Federated Rural Electric Insurance Corporation came to the Department to discuss the possibility of changing the legal residence of the corporation from Wisconsin to Kansas. While the company is legally incorporated in the state of Wisconsin, its executive offices are located in Johnson County, Kansas. In addition to wanting to change its legal domicile to Kansas, the company wants to change its legal structure from a stock corporation to a reciprocal or inter-insurance exchange. A reciprocal or inter-insurance exchange is a legal agreement between a number of persons or companies, in which they all agree to insure or indemnify each other against losses. That agreement provides for an "attorney-in-fact," which is the legal entity that manages or administers the agreement and operation of the reciprocal. It is somewhat like a mutual insurer, in that the insured people or companies are owners of the insuring mechanism, but it is less formal and it does offer some federal tax benefits that are difficult to accomplish with a mutual or stock company.

Senate Financial Institutions & Insurance
Date 3/31/99
Attachment # 2

420 SW 9th Street
Topeka, Kansas 66612-1678

785 296-3071
Fax 785 296-2283

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

In reviewing the Insurance Code, it is clear our current statutes do not address this situation. We are interested in helping the company accomplish these two goals, i.e. redomesticating and converting from a stock to a reciprocal company, in a one-step, seamless transaction.

SB 356 provides a statutory process to allow greater flexibility in forming reciprocals or inter-insurance exchanges. We have encouraged the company to include provisions in this bill that provide for a process that is comparable to what you will find in our statutes governing merger or conversion of insurance companies or associations (K.S.A. 40-4001 et seq.).

We also encouraged the Revisor's office to make the new statutory process as "generic" as possible. We believe the reciprocal mechanism, which is not widely used at present, is an attractive way to structure an insuring entity. We also believe the statute should be flexible to allow others to use this method of corporate governance, as an alternative to stock or mutual company structures.

I would respectfully ask that you approve SB 356.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Financial Institutions & Insurance

FROM: Linda De Coursey

RE: SB 356 -- Establishing a procedure for the conversion of a stock or mutual insurance company into an insurance reciprocal.

Mr. Chairman and members of the Committee:

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2-3

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We also encouraged the Revisor's office to make the new statutory process as "generic" as possible. We believe the reciprocal mechanism, which is not widely used at present, is an attractive way to structure an insuring entity. We also believe the statute should be flexible to allow others to use this method of corporate governance, as an alternative to stock or mutual company structures.

I would respectfully ask that you approve SB 356.

For Senate Committee on Financial Institutions and Insurance

March 31, 1999

Sub. For SB 80 – External Review Procedure

Kathleen Sebelius, Insurance Commissioner

Attached is our suggestion for Sub. For SB 80. Because of the extensive amending, we suggest looking at the bill in the cleaner format. Agreed upon changes are:

- Change in the definition of External Review Organization (ERO). (pg 2)
- Add an exception if a delay in the review is requested by the insured (pg 4)
- Added confidentiality requirements for medical records privacy for commissioner and the external review organization. (pg 4 and 6)
- Added language that requires the ERO to inform the commissioner in writing the basis and ration for their decision with regards to the medical necessity, and experimental or investigational treatment
- Added language that precludes an insured from having two external reviews on the same case, one with federal and one with state.
- Effective date of the bill: January 1, 2000.

Most of the language found in this version of the bill has been signed off by interested parties of the bill. What I think we should focus on are the points of contention that still exist:

- Placing a statute of limitation on the insured by requesting that the insured file an external review request within a certain time frame.
- Stating in law that the insured's treating physician or provider complete a written opinion that the treatment is medically necessary. IC wants this
- The Standards of decision making based on clinical review criteria instead of based on verifiable medical and scientific evidence.
- Decision of the ERO is binding on the insurer or plan.

Senate Financial Institutions & Insurance
Date 3/31/99
Attachment # 3

Session of 1999

Sub for SENATE BILL No. 80
By Committee on Financial Institutions and Insurance
1-21

AN ACT relating to accident and health insurance; concerning an external review process; providing certain requirements.

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

Section 1. (a) For purposes of this act:

(1) ``Adverse decision'' means a utilization review determination by a third-party administrator, a health insurance plan, an insurer, or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and, (a) if the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services, or (b) the adverse decision is the reason for the insured not receiving the requested services.

(2) ``Health insurance plan'' means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. Health insurance plan does not include policies or certificates covering 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 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.

(3) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group funded pool, and the self-funded coverage established by the state of Kansas for its employees.

(4) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group funded pool, and the self-funded coverage established by the state of Kansas, or any hospital or medical expense, health, hospital or medical service corporation contract, or a plan

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provided by a municipal group-funded pool.

(5) "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall have experience serving as the external quality review organization in health programs administered by the state of Kansas, or be a nationally accredited

external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event no Kansas providers are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in their practice outside the state of Kansas.

(6) "Emergency medical condition" means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, or serious dysfunction of a bodily organ or part, or would place a person's health in serious jeopardy.

Sec. 2 (a) The right to review under this act shall not be construed to change the terms of coverage under a health insurance plan or insurance policy.

(b) The insurer or health insurance plan shall provide written notice to the insured of a final adverse decision and the opportunity for requesting an external review.

(c) The insured has the right to request an independent external review of an adverse decision by a health insurance plan or insurer when: (1) The insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has a emergency medical condition, in which case an expedited procedure is used; or (2) The the insured has not received a final decision from the insurer within 60 days of seeking the internal review, except to the extent that the delay was

requested by the insured.

(d) The external review shall be requested in writing to the commissioner from the following persons: (i) the insured, or (ii) the treating physician or health care provider acting on behalf of the insured with written authorization from the insured, or (iii) legally authorized designee.

(e) The insured shall provide all information in the possession of the insured pertaining to the adverse decision in order for the commissioner to make a preliminary determination for an external review. The insured shall also provide the commissioner with an appeal form, and a fully executed release for the commissioner and the external review organization to obtain any necessary medical records form the insurer or health insurance plan and

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any other relevant provider.

(f) In responding to the commissioner, the insurer or health insurance plan shall provide a copy of the adverse decision given to the insured and all medical and other records pertaining to the insured's claim within 5 business days of the request of the commissioner.

(g) The confidentiality of any medical information submitted by insured, on behalf of the insured, insurer, or health insurance plan, shall be maintained pursuant to applicable state and federal laws.

Sec. 3. (a) The commissioner shall:

(1) Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health insurance plan

or insurer.

(a) The external review organization as defined in Section 1(a) (5) of this act shall provide that all reviews completed pursuant to this act are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the performance of their duties in this act.

(b) The reviews shall be completed in accordance with standards of decision-making based on clinical review criteria and shall resolve all issues within 30 business days. The external review organization shall issue a written decision to the commissioner including the basis and rationale for the decision. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary and appropriate under the insured's contract. In reviews regarding experimental or investigational treatment, the external review organization shall state reasons that the requested treatment should or should not be provided by the health insurance plan or insurer, based on the insured's medical condition.

(c) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues within 7 business days.

(d) The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

(e) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured for any opinion

rendered as part of the an external review conducted pursuant to this act.

(f) The external review organization shall maintain confidentiality of the medical records of insured, in accordance to state and federal law.

(2) Allow the insurer or the health insurance plan, an insured or treating physician or health care provider acting on behalf of the insured, or legally authorized designee filing a request for external review to provide additional written information as may be relevant for the commissioner to make a final decision on whether the request qualifies for external review.

Page ___

(3) Make a decision on a request for external review within 10 business days after receiving all necessary information.

(4) Notify the insured and treating physician or health care provider acting on behalf of the insured, or legally authorized designee, and insurer or health insurance plan in writing that a request for external review will or will not be granted.

(5) Design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision.

Sec. 4. (a) The decision of the external review organization shall be:

(1) binding as to payment or provision of services on the health insurance plan or insurer, and (2) except as to (1), the external review organization decision is binding to the extent the insured, insurer, or health insurance plan has other remedies applicable under state or federal law.

(b) In the event external review processes are available pursuant to federal

law and this act, the insured shall have the option of designating which external review process will be utilized.

(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by this act. The rules and regulation shall ensure that the commissioner is able to provide for an effective and efficient external review of health care services.

Sec. 5. This act shall take effect and be in force from and after January 1, 2000, and its publication in the statute book.

INDUSTRY BALLOON NO. 1

[Allowing the Legislature to determine the scope of the review and the requirements of the review determination, rather the delegating to the Commissioner through rules and regulations.]

( ) The determination by the external review organization shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The external review organization shall make determinations based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary", and shall not expand the contractually agreed upon coverage. The determination of the external review organization shall specifically cite the relevant provisions in the evidence of coverage, the insured's specific medical condition and the relevant documents provided pursuant to subsection (___), to support the determination by the external review organization, and the reviews shall be done in accordance with the standards of decision making based on verifiable medical and scientific evidence.

( ) In reviews regarding experimental or investigational treatment, the external review organization shall state the reasons that the external review or should not be provided by the plan, based upon the insured's medical condition, the relevant documents and the preponderance of medical and scientific evidence.

Senate Financial Institutions & Insurance

Date 3/31/99

Attachment # 4

INDUSTRY BALLOON NO. 2

[Legitimizing the review process: binding on both parties; rebuttable presumption of correctness; court appeals 30 days after review decision; court appeals on the record; no impact on existing causes of action.]

( ) The determination of the external review organization shall be binding on the insurer and the insured, except to the extent the insured has other existing remedies available under applicable federal or state law. The determination of the external review organization shall create a rebuttable presumption in any subsequent action at law that the reviewer's coverage determination was appropriate. Any judicial appeal of the determination of the external review organization shall be filed within 30 days of the date of the written determination by the external review organization and shall be confined to the record developed by the external review organization.

INDUSTRY BALLOON NO. 3

[Limiting external reviews to one/year on the same set of facts; and to either, but not both, state or federal review processes.]

( ) In no event shall more than one external review be available during the same year for any request arising out of the same set of facts. An insured may not pursue, either concurrently or sequentially, an external review process under both a federal and state law. In the event external review processes are available pursuant to federal law and this act, the insured shall have the option of designating which external review process will be utilized.