Approved: 2-6-01
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Sandy Praeger at 9:30 a.m. on January 31, 2001 in Room 234-N of the Capitol.

All members were present except:

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department
Ken Wilke, Office of the Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:

Pam Scott, Kansas Funeral Directors Association
Senator Janis Lee
Dr. Ernest Pogge, AARP
Steve Rarrick, Deputy Attorney General, Consumer Protection Division
Chuck Stones, Kansas Bankers Association
Doug Smith, Direct Marketing Association
Caroline Williams, Consumer Service, Western Resources
Linda DeCoursey, Director of Government Affairs, Kansas Insurance Department

Others attending: See attached list.

Introduction of bills

Senator Feleciano made a motion that the Committee introduce legislation relating to credit scoring, seconded by Senator Barnett. The motion carried.

Pam Scott, Kansas Funeral Directors Association, requested introduction of a bill relating to insurance agents selling life insurance of annuity products used to fund a prearranged funeral program. Senator Brungardt made a motion that the Committee introduce the proposed legislation, seconded by Senator Teichman. The motion carried.

Hearing on SB 58 - Consumer protection; prohibiting obtaining or submitting check without written consent

Senator Janis Lee testified in support of **SB 58** which would protect consumer rights by prohibiting a supplier of goods and services as defined under the Kansas Consumer Protection Act from obtaining or automatically withdrawing money from a person's checking, savings, or similar account, without express written authorization as stipulated in the bill. Senator Lee noted that she first became concerned with the fact that no consumer signature is required for a bank's withdrawal of funds when a situation in her family brought this to her attention. She also pointed out that she would work with opponents of the bill to determine if there is a middle ground on this issue. (Attachment 1)

Dr. Ernest Pogge, AARP, spoke in support of the bill and noted that telemarketing fraud victimizes people of all ages by using verbal authorization to access the consumer's account before the consumer has the opportunity to adequately respond. He also felt that written authorization would amend this situation as noted in his written testimony. (Attachment 2)

Steve Rarrick, Deputy Attorney General, Consumer Protection Division, provided testimony to the Committee in support of **SB 58** . Mr. Rarrick noted that his office has received numerous complaints from consumers who have had money taken from their bank accounts without their knowledge or they expressed concern because they gave their bank account number to a telemarker. (Attachment 3) During Committee discussion Mr. Rarrick stated that he would not object to utilities regulated by KCC to properly withdraw funds, but felt that more work needed to be done to strengthen an amendment allowing telemarkers such access.

Chuck Stones, Kansas Bankers Association, a neutral conferee, provided information to the Committee relating to telemarketing problems, bank liability, avoiding losses by the consumer, educating bank customers on fraud, and new Federal Trade Commission rules on prohibiting deceptive telemarketing practices. (Attachment 4) During Committee discussion Mr. Stones noted that it is the responsibility of a bank to pay a draft if it is properly payable, and that the consumer has the responsibility of checking their bank account statement and not giving out their bank account number to unauthorized persons.

Doug Smith, Direct Marketing Association, spoke in opposition to the bill, and urged the Committee to keep Kansas consistent with federal law on the issue of electronic payment. He requested the Committee amend **SB 58** so that it is consistent with the Telemarketing Sales Rule, which is a part of the Telemarketing and Consumer Fraud and Abuse Prevention Act, as noted in his written testimony. (Attachment 5)

Caroline Williams, Consumer Service, Western Resources, also spoke in opposition to **SB 58** because she felt by requiring written authorization instead of oral authorization, this bill would effectively eliminate the convenience of service to customers in paying their utility bills which could result in the disconnection of service due to the time requirement of submitting written authorization. Ms. Williams offered an amendment that would exempt public utilities regulated by the Kansas Corporation Commission from the written authorization as shown in a balloon of the bill. (Attachment 6)

The Chair noted that Senator Lee is willing to work with opponents of the bill to draft an amendment to the bill that would be agreed to by all parties. Senator Lee agreed to bring such language back to the Committee for their consideration.

Hearing on SB 101 - Health Insurance; HIPAA technical changes

Linda DeCoursey, Director of Government Affairs, Kansas Insurance Department, testified in support of **SB 101** which is technical in nature and brings Kansas group accident and sickness insurance law into compliance with the Health Insurance Portability and Accountability Act of 1996 as outlined in her written testimony. (Attachment 7)

There were no opponents to **SB 101**.

Adjournment

The meeting was adjourned at 10:20 a.m. The next meeting of the Committee is scheduled for February 1, 2001.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 1-31-01

NAME	REPRESENTING
Anne Spiess	KAIA
Linda McCarney	KID
Carolyn Middaugh	Ks St Nurses Assn
Tami Lin Porter	KAHP

STATE OF KANSAS

JANIS K. LEE
ASSISTANT MINORITY LEADER
STATE SENATOR, 36TH DISTRICT
BARTON, ELLSWORTH, JEWELL,
LINCOLN, MITCHELL, OSBORNE,
PHILLIPS, REPUBLIC, RUSSELL
AND SMITH COUNTIES
RR 1, BOX 145
KENSINGTON, KANSAS 66951
(785) 476-2294 HOME
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TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS
RANKING MEMBER: ASSESSMENT & TAXATION
MEMBER: EDUCATION
PUBLIC HEALTH AND WELFARE
UTILITIES
LEGISLATIVE EDUCATIONAL PLANNING
SRS TRANSITION OVERSIGHT

Madam Chairman and Committee Members

I very much appreciate this opportunity to testify on SB 58.

SB 58 came about because of a situation in my family which brought to our attention the fact that no consumer signature is required for a supplier to issue and receive payment for a draft, check, or other form of negotiable instrument drawn on that consumer's checking, savings, or similar account in a bank.

My brother and I assist an elderly aunt and uncle of our's with their personal financial matters because they have no children. This past fall and insurance company attempted to sell my aunt a supplemental health insurance policy. After some conversation she indicated that she was not interested in the product. To her surprise there was a debit on her next bank statement for $85 + from that insurance company. She contacted the bank and they sent hers forms for her to sign to stop the automatic payment for which the insurance company had sent a draft.

When we discussed the situation with the bank, we were dumbfounded to discover that no signatures were required for a draft to be taken from a person's checking account. The bank further explained that several years ago they were required to have signed documents from their customers before an automatic withdrawal draft could be taken out of their bank account. However, that requirement is no longer in effect.

Because of our experiences helping our elderly parents and now our elderly relatives, we are very aware of how vulnerable senior citizens can become. It is also evident that senior citizens are quite often the prime target for unscrupulous individuals and businesses. Not requiring a signature before a withdrawal can be made from a person's bank account certainly makes this segment of our population, as well as anyone who does not examine their bank statement on a regular basis, even more vulnerable.

I am aware that there is some opposition to SB 58 from special interest groups. I am willing and open to discussion to determine if there is any middle ground on this issue.

However, ultimately as legislators we must ask ourselves whether we are more interested in providing reasonable protection for the innocent consumer or in listening to those who desire no changes and thus leave open the opportunity for some to take advantage of the unsuspecting public.

Senate Financial Inst. & Insurance
Date: 1-31-01
Attachment No. 1

AARP *in Kansas*

AARP Kansas Business Center
Southwest Plaza Office Building
3601 SW 29th Street, Suite 125
Topeka, KS 66614
(785) 228-2557
(785) 228-2531 Fax

January 31, 2001

Good morning Senator Praeger and Members of the Senate Committee on Financial Institutions and Insurance. My name is Dr. Ernest Pogge. I am a volunteer member of our AARP Kansas State Legislative Committee, which represents the views of our more than 350,000 members in Kansas. I am also the Coordinator of our Capital City Task Force, which is the lobbying arm of our State Legislative Committee. Thank you for this opportunity to speak in *support* of Senate Bill 58.

Telemarketing fraud and other forms of fraud victimizes people of all ages, ethnic groups, educational backgrounds and income levels. Unfortunately, unscrupulous telemarketers and other suppliers often target older Americans.

AARP supports access to consumer's bank, savings, trust, stock or bond accounts by a supplier only after receipt of written consent by the consumer. Fraudulent telemarketers, for example, use verbal authorization to access the consumer's account before the consumer has the opportunity to adequately consider the high pressure telephone sale. The FTC Rule permits access to consumer accounts with "verifiable authorizations". One form of verifiable authorization includes verbal consent from consumers that is supposed to be tape recorded by the telemarketer. The telemarketer must maintain the tape and upon request from the consumer's bank make the tape available. However, banks are under no obligation to request the tape prior to making payment to the telemarketer. Once the bank makes the payment to a fraudulent telemarketer, the consumer's money is lost.

Therefore, AARP only supports written authorization. Thank you again for this opportunity. I stand ready to answer questions.

Senate Financial Inst. & Insurance
Date: 1-31-01
Attachment No. 2

State of Kansas
Office of the Attorney General
CONSUMER PROTECTION/ANTITRUST DIVISION
120 S.W. 10TH AVENUE, 2ND FLOOR, TOPEKA, KANSAS 66612-1597
PHONE: (785) 296-3751 FAX: 291-3699

CARLA J. STOVALL
ATTORNEY GENERAL

CONSUMER HOTLINE
1-800-432-2310

Testimony of
Steve Rarrick, Deputy Attorney General
Consumer Protection Division
Office of Attorney General Carla J. Stovall
Before the Senate Financial Institutions & Insurance
RE: SB 58
January 31, 2001

Chairperson Praeger and Members of the Committee:

Thank you for the opportunity to appear before you this morning on behalf of Attorney General Carla J. Stovall to testify in support of SB 58. My name is Steve Rarrick and I am the Deputy Attorney General for Consumer Protection.

This bill addresses a growing problem of unauthorized withdrawals from consumers' checking and savings accounts. As drafted, the bill would prohibit suppliers from obtaining or submitting for payment, "other than for the continuation of existing and recurrent services" a "check, draft, or other form of negotiable instrument or payment order drawn on a person's checking, savings, share or similar account without the consumer's express written authorization." Many people are surprised when they learn that money can be removed from their financial institution accounts without their signature.

Our office has received numerous complaints and inquiries from consumers who have (1) had money taken from their bank account without their knowledge or (2) inadvertently given their bank account number to a supplier and become worried the supplier could illegally access their account. This scenario is most prevalent in transactions involving telemarketing. Unscrupulous telemarketers have, after a convincing sales pitch, convinced consumers to provide their checking account and bank routing numbers to the telemarketer. Then, with or without the consent of the consumer, the telemarketer has submitted a demand for payment to the consumer's financial institution.

Once money has been paid out by a financial institution, it is extremely difficult to get it back. Unlike credit cards, checking accounts do not have verification protections such as an expiration date to verify possession of the card. As a result, any unscrupulous person or business who obtains the checking account number is able to draw money from the consumer's account. Perhaps more importantly, checking accounts do not have the federal protection which provides a process for the consumer to contest payment of the bill. Once paid, the money is simply gone from the account. This can lead to unhappy relations between consumers and their financial institutions.

Senate Financial Inst. & Insurance
Date: 1-31-01
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Kansas financial institutions often find themselves caught between their customer who denies authorizing payment, and the supplier requesting payment. This is usually a no-win situation for financial institutions. If they pay the amount submitted, their customers are unhappy and may sue and/or take their business elsewhere. If they deny payment, the supplier may sue for payment. Our office believes this bill will resolve this dilemma.

I have attached to my testimony a letter from Deputy District Attorney Joe Kisner, on behalf of Sedgwick County Attorney Nola Foulston, in support of SB 58.

On behalf of Attorney General Stovall, I urge your favorable consideration of SB 58. I would be happy to answer any questions of the chair or the members. Thank you.

OFFICE OF THE DISTRICT ATTORNEY
EIGHTEENTH JUDICIAL DISTRICT OF KANSAS

NOLA FOULSTON
District Attorney

JOE KISNER
Deputy District Attorney/Civil
<jkisner@sedgwick.gov>

at the SEDGWICK COUNTY COURTHOUSE
535 N. MAIN STREET
WICHITA, KS 67203

Consumer Fraud & Economic Crime Division
(316) 383-7921
{Fax} 383-7266

January 30, 2001

The Honorable Sandy Praeger, Chair
Senate Financial Institutions & Insurance Committee
Kansas Senate
State Capitol Building, Rm 255-E
Topeka, KS 66612

RE: Senate Bill 58
Hearing Scheduled before the Committee - January 31, 2001

Dear Senator Praeger and Members of the Committee:

District Attorney Nola Foulston joins Attorney General Stovall in requesting your consideration of SB 58. This bill addresses a growing problem of unauthorized withdrawals from consumer's checking or savings accounts.

Each time a consumer writes a check and delivers it to some entity, that consumer discloses his or her account number. In addition, consumers mistakenly give their account numbers out over the telephone or by other means and those numbers are subject to fraudulent misuse.

This bill, as drafted, would require some written authorization before a payee could obtain or request money out of a consumer's account. A citizen's bank/savings account is a very personal and private asset. The owner(s) of each account should have complete and clear control over who has access to such an account(s) and the funds therein. This type of legislation will insure that control and protect those accounts from many fraudulent practices.

Your consideration is greatly appreciated.

Respectfully,

Joe Kisner
Deputy District Attorney

JK/wpd

cc: The Honorable Paul Feleciano

Chuck Stones
KBA

UNAUTHORIZED PAPER DRAFTS

■ Need for "Authorization"

Under the Uniform Commercial Code, banks have a responsibility to pay only those items which are "***properly payable***." To be properly payable, an item must be ***authorized*** by the account holder. An account holder "authorizes" payment of a regular bank check by ***signing*** that check. But a "draft" is not signed by the account holder. A draft is an order (to the bank) by a third person to pay the third person with funds from the account holder's account. Like checks, the draft is properly payable only if payment is authorized by the account holder, but since the draft is not signed, it is difficult to determine whether these paper drafts have actually been authorized.

■ Telemarketing Problems

Paper drafts are commonly used by insurance companies and utility companies; these insurance/utility drafts are typically authorized by the account holder and rarely create a problem for the bank. Most problems relating to unauthorized paper drafts arise out of ***telemarketing*** practices. Telemarketing companies market products over the telephone, and have, in some instances, presented unauthorized drafts. Not all telemarketing is inappropriate; most telemarketing companies—annoying as they may be—are reputable companies who properly use the telephone to generate legitimate sales. But a few telemarketers have used information received over the phone to prepare unauthorized paper drafts. For example, an unscrupulous telemarketer might ask a bank customer to give his/her checking account number (or bank routing number) so that the telemarketer can "verify" that the customer has won a prize. Once the telemarketer has those numbers (and there are numerous schemes enabling the telemarketer to obtain that information), he/she can use them to prepare an unauthorized draft against the customer's account. These drafts look just like a check, except the customer's ***actual signature*** is ***missing***. In some cases, the customer's name is printed in the signature space; other drafts contain a notation claiming that the "signature" is authorized.

■ Bank Liability

If the customer gives the telemarketer his/her account number and ***understands*** that the number will be used to draft funds out of the customer's checking account, the draft is indeed "authorized" and is properly payable. But if the customer gives the number for some other reason (like verifying a prize) and ***does not understand*** that the number will be used to debit funds from his/her account, the resulting draft is "unauthorized" and is not properly payable. If the bank pays an unauthorized (not properly payable) draft and the customer complains, the bank will be required to ***re-credit the customer's account*** and take the loss. The draft ***cannot be returned*** to prior banks because determining whether a draft is "authorized" is the responsibility of the bank on which the draft is drawn.

■ Avoiding Losses

Bankers should be aware of the risks associated with unauthorized paper drafts, but this is not to say that all drafts must be individually scrutinized and dishonored. In fact, common sense would suggest that most drafts should be paid without question. It is not likely, for example, that a draft presented by Blue Cross Blue Shield (or a utility company) is unauthorized. But drafts presented by ***unfamiliar businesses*** should be closely ***scrutinized***. Where the bank finds an unsigned draft presented by an unfamiliar payee, it should consider ***contacting the account holder*** to determine whether the draft is authorized. If it is not authorized, the draft must be returned through the check-collection system by the bank's midnight deadline.

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Practical Considerations

As indicated above, a bank can avoid liability by verifying customer authorization on suspicious drafts. In many cases, however, it is ***more practical to simply pay*** every draft without question and re-credit the customer's account in the event a draft turns out to be unauthorized. Similarly, a bank could choose to pay smaller drafts without question, but ***verify authorization on larger items***. Under these policies, the bank simply accepts the fact that it might unknowingly pay a few unauthorized drafts for which it will be liable. This can be a legitimate business decision in which bank management concludes that the cost of a few unauthorized drafts will be less than the cost of routinely verifying customer authorization. Banks with these "just-pay-it" policies consider unauthorized-draft losses part of the cost of doing business.

Educating Customers

Perhaps the best way to control unauthorized-draft losses is to ***educate bank customers***. Bankers might consider using ***statement stuffers*** to warn of possible telemarketing fraud. Likewise, banks can work with the ***local newspaper*** to alert the public about telemarketing problems. And since telemarketing fraud is often aimed at the elderly, banks may want to consider a short ***seminar or "town meeting"*** to discuss the matter with its older customers. Customers should be advised to never give any account information to anyone over the telephone. Once customers understand this "rule," unauthorized-draft problems will significantly diminish. Also be aware that Bankers Systems sells a pre-printed ***brochure*** which advises bank customers of telemarketing scams.

New FTC Rule

In September 1994, Congress passed the Telemarketing and Consumer Fraud and Abuse Prevention Act which directs the Federal Trade Commission (FTC) to issue rules prohibiting deceptive telemarketing practices (15 U.S.C. §6102). Pursuant to this Act, the FTC originally proposed a rule that would have required telemarketers to obtain ***written*** authorization before issuing a draft against a consumer's account. That requirement was ultimately deleted, however, and the final rule simply prohibits a telemarketer from issuing a draft without "express verifiable information." An authorization is "verifiable" if it is:

- In writing;
- Tape recorded and made available to the consumer's bank upon request; or
- Confirmed by a writing sent to the consumer prior to submitting the check for payment.

While not fool proof, this relatively new regulation may be successful in limiting the number of unauthorized telemarketing drafts.

Other Common Draft Situations

While most paper drafts will be drawn by utility companies, insurance companies and telemarketers, there are some other situations in which paper drafts will commonly be drawn against a customer's account. One company, for example, is advertising a new "***checks-by-fax***" system (CHAX). This system, being marketed to businesses, would apparently enable the business's customer to make payment by faxing (instead of mailing) a check. It is unclear how this system works, but it is likely that the company uses the faxed check as an "authorization," then issues its own paper draft against it's customer's account. Other types of paper draft situations might include drafts issued by ***collection agencies*** to obtain payment from a debtor's account; and drafts drawn by ***casinos*** to cover a person's gambling expenses.

Different Rule for EFT's

Finally, note that a payor bank will be liable for an unauthorized debit only if the debit arises as a result of a ***paper draft***. If an electronic funds transfer ***(EFT) debit is unauthorized***, special NACHA rules put the liability squarely on the ***originating bank*** (and not the account holder's bank).

TESTIMONY

Senate Financial Institutions and Insurance Committee
Senate Bill No. 58
January 31, 2001

Presented by Douglas E. Smith
DIRECT MARKETING ASSOCIATION

Chairperson Praeger and Members of the Senate Financial Institutions and Insurance Committee:

Thank you for the opportunity to appear here today. My name is Doug Smith and I am presenting testimony on behalf of the Direct Marketing Association. The Direct Marketing Association (DMA), is the oldest and largest national trade association, serving the direct marketing industry since 1917, with over 4,700 members.

In general, direct marketing involves a company soliciting a consumer to offer goods or services, or a consumer requesting goods or services in response to a mailing or advertisement.

It can be very hard to distinguish between reputable marketers and the fraudulent ones. You can't tell by the person's voice or convincing sales pitch. But you can tell by the offers that they make -- "free" trips, fabulous prizes and sweepstakes or great money making opportunities. These valuable offers should send up an immediate warning flag for consumers to exercise caution. Consumers need to know that they can protect themselves and that other groups and organizations are out there to help them learn how to protect themselves

Thanks to the **Telemarketing and Consumer Fraud and Abuse Prevention Act**, passed in 1994, and the education efforts of the Federal Trade Commission, National Association of Attorneys General and Better Business Bureaus telemarketing fraud is no longer in the "Top 10 List" of consumer complaints.

In August of 1995, the Federal Trade Commission developed the **Telemarketing Sales Rule** ("TSR"), as a part of the 1994 federal legislation to protect consumers from telemarketing fraud. They implemented among many others a provision allowing demand drafts. The drafts are also known as "phone checks". When the FTC created the rules and regulations for the TSR they established a requirement for "express verifiable authorization" as an effective mechanism for protecting consumers while protecting their rights to spend their money as they wish.

The "verifiable authorization" provision means that there must be active participation from the consumer, not just a reaction of acceptance. According to the TSR, the requirement for verifiable authorization can be satisfied in 3 ways; *(1) an advance written authorization from the consumer, (2) a tape recording of the consumer giving their authorization, or (3) a written confirmation of the transaction.* The Seller must keep the consumer's verifiable authorization for two years from the date of authorization.

Not only must the consumer be informed that monies are being withdrawn from their bank account by a "phone check", but federal law also requires that the following information be clearly disclosed to a consumer in any taped authorization:

- The date of the draft;
- The amount of the draft;
- The name of the consumer whose account is being debited;
- The number of payments authorized, if more than one;
- A customer service telephone number answered during normal business hours and
- The date of the authorization.

The Direct Marketing Association urges you to keep Kansas consistent with federal law on the issue of electronic payment. The use of phone checks has a multi-billion dollar impact on the industry. Fortune 100 companies all the way down to small home-based businesses utilize these payments. We ask that you amend Senate Bill No 58, so that it is consistent with the Telemarketing Sales Rule, which is a part of the Telemarketing and Consumer Fraud and Abuse Prevention Act

Who uses "phone checks"? Companies like Sears, Olan Mills, Allstate, Jenny Craig, JC Penney and hundreds of other businesses in Kansas.

Allowing consumers to pay by check over the telephone is a payment option designed to not only permit consumers to purchase when they want, but offers an alternative to using credit cards or the hassle with mailing a check. The "phone checks" are convenient and used by all segments of the population. This form of payment allows consumers who do not possess or use credit cards, those who are unable to get to the post office to mail a check, and those wishing to make purchases and receive them in a timely fashion, the same conveniences as those who use a credit card. These phone checks are a safe, legal and speedy method for paying bills and ordering goods and services.

Eliminating this convenient method of payment will not get rid of any problems, because fraudulent marketers simply don't abide by the law. Thus, the legitimate companies and responsible citizens of Kansas will be negatively impacted by unduly restrictive and burdensome business practices.

The "express verifiable authorization" provisions of the TRS regarding the treatment of automated payment methods are sufficient to establish consumer intent and protect against fraud.

Thank you for your consideration.

Testimony
Before the Senate Financial Institutions and Insurance Committee
By
Caroline Williams, Vice President, Customer Service
Western Resources
January 31, 2001

Chairman Praeger and members of the Committee:

Western Resources is opposed to SB #58 in its original form regarding the requirement for express written authorization on the part of a consumer before a check could be drawn on the consumer's checking, savings, share or similar account.

Customer Impact: Both KPL and KGE currently offer a service to customers called phone check. A phone check is created when a customer advises the company either orally, or through our automated Interactive Voice Response (IVR) system, he/she wishes to pay by "phone check." The customer provides a check number, the checking account number, and bank number to utilize this service. The transaction is completed by printing a check and sending it to the customer's bank for processing.

The convenience of phone checks has become quite popular among customers as a one-time, as well as, a recurring method of payment. The increased usage is illustrated in the attached spread sheet that represents the number of customers opting to utilize this service. As the spreadsheet shows, this service has been extremely well received since its introduction in October 1998. In that time, we have had no complaints that we have misapplied funds or failed in any way to follow the payment instructions of any of our customers.

In addition to this option being available for all customers, it is especially useful and convenient for a customer who has been sent a disconnect (cutoff) notice, whereby the customer can simply call the company and advise the utility to write a check to the customer's bank, either orally or automatically through our (IVR) system, to avoid having electric services shut off. This service can prevent unnecessary disconnection/reconnection and the associated charges being incurred by a customer. By requiring written authorization, as stated in SB #58 , this bill would effectively eliminate the convenience of this service to our customers and could result in the disconnection of utility service due to the time requirement to submit written authorization.

Additionally, due to numerous customer requests, we are planning to offer this service through our web site in the form of a web check in the near future.

Suggestion: In order to allow this customer service to continue, we suggest the following amendment to SB #58: (Balloon attached)

New Sec.2 (a) "No supplier, other than a public utility regulated by the State Corporation Commission, shall obtain or submit for payment, ..."

Senate Financial Inst. & Insurance
Date: 1-31-01
Attachment No. 6

In order for KPL/KGE to continue to offer this time and money-saving phone check service to our customers, we respectfully request the committee amend SB #58 as described. Creating this exception to the coverage of the bill will not harm consumers since they will have recourse to the Commission to address any issues which arise out of our provision of the phone check service.

Telephone Checks

1998	IVR	CSR	Total	Amount Received
January				
February				
March				
April				
May				
June				
July				
August				
September				
October			2,654	$428,935.24
November			2,491	$314,711.25
December			2,077	$242,418.71
Total			**7,222**	**$986,065.20**

1999	IVR	CSR	Total	Amount Received	
January			2,436	$302,317.22	
February			3,571	$521,141.70	
March	39	5,563	5,602	$913,242.55	*
April	221	5,866	6,087	$982,412.27	
May	261	4,959	5,220	$829,686.16	
June	342	5,147	5,489	$841,873.02	
July	394	4,637	5,031	$831,963.19	
August	512	5,416	5,928	$905,445.61	
September	726	6,372	7,098	$1,212,030.90	
October	796	7,088	7,884	$1,323,461.70	
November	695	5,574	6,269	$1,188,436.74	
December	689	4,843	5,532	$1,040,950.31	
Total	**4,675**	**55,465**	**66,147**	**$10,892,961.37**	

* Late March 99 added phone check to IVR

2000	IVR	CSR	Total	Amount Received
January	943	5,864	6,807	$1,315,093.24
February	1,209	7,982	9,191	$1,953,544.55
March	1,394	9,769	11,163	$2,106,939.46
April	1,210	8,656	9,866	$1,979,946.45
May	1,342	8,475	9,817	$1,827,415.49
June	1,311	7,564	8,875	$1,598,558.02
July	1,301	6,955	8,256	$1,583,353.49
August	1,804	9,167	10,971	$2,407,471.89
September	1,870	10,284	12,154	$2,767,559.27
October	2,122	12,099	14,221	$3,033,238.54
November	1,787	9,848	11,635	$2,120,402.80
December	1,781	8,882	10,663	$1,870,974.28
Total	**18,074**	**105,545**	**123,619**	**$24,564,497.48**

Session of 2001

SENATE BILL No. 58

By Committee on Financial Institutions and Insurance

1-18

AN ACT relating to consumer protection; prohibiting certain acts.

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

Section 1. (a) No supplier shall obtain or submit for payment, other than for the continuation of existing and recurrent services, a check, draft or other form of negotiable instrument or payment order drawn on a person's checking, savings, share or similar account without the consumer's express written authorization.

(b) Express written authorization by a consumer includes:

(1) The consumer's signature on a check, draft or other form of negotiable instrument or payment order; or

(2) the consumer's signature on a separate written agreement authorizing single or periodic payments by check, draft or other form of negotiable instrument or payment order.

(c) Nothing in this section shall prohibit a consumer from personally directing the consumer's financial institution to make payment from the consumer's checking, savings, share or similar account via electronic or telephonic means in accordance with procedures set by the consumer's financial institution, nor shall this section affect the right of a consumer to transfer funds from one account to another.

(d) A violation of subsection (a) is an unconscionable act within the meaning of K.S.A. 50-627, and amendments thereto.

(e) This section shall be part of and supplemental to the Kansas consumer protection act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

, other than a public utility regulated by the state corporation commission,

4-9

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda J. De Coursey, Director of Government Affairs

RE: SB 101 (Technical changes to law; HIPAA)

DATE: January 31, 2001

Madam Chairwoman and members of the committee:

I am appearing in support of Senate Bill 101, which was introduced at the request of the Kansas Department of Insurance. The bill is technical in nature and brings Kansas group accident and sickness insurance law into compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996). Please find attached a recent bulletin from Health Care Financing Administration (HCFA) about the "succeeding-carrier" or "extension of benefits" laws and an insurer's obligation under HIPAA.

In 1997, the Kansas Legislature passed SB 204, which implemented HIPAA in our state law. Since that time, HCFA has issued various regulations, rulings, and bulletins to further clarify the federal law. Sometimes their determinations cause our laws to become non-compliant with HIPAA.

The attached Bulletin addresses the situation in which an employer with a disabled employee or dependent switches the group health plan coverage from one insurer (prior carrier) to another (succeeding carrier). We need to change our law to state that the succeeding carrier cannot eliminate its legal obligation to enroll an individual who is disabled at the time that the original

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health insurance coverage is terminated. In other words, the succeeding carrier must enroll all employees at the same time, even if one is in the hospital.

We believe that the language in this bill accomplishes that directive. I respectfully ask that when the committee considers SB 101, to please consider it favorably for passage.

ADVANCE COPY OF FINAL ISSUANCE

PROGRAM MEMORANDUM INSURANCE COMMISSIONERS INSURANCE ISSUERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. 00-04 **Date** August 2000

Title: Insurance Standards Bulletin Series -- INFORMATION

Subject: State "succeeding-carrier" or "extension of benefits" laws and an issuer's obligation under HIPAA to enroll an eligible individual who is disabled[1].

Markets: Group

I. Purpose

This bulletin conveys the position of the Health Care Financing Administration (HCFA) on the relationship between State "succeeding-carrier" laws and the insurance reform provisions of Title XXVII of the Public Health Service Act (PHS Act), as added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A number of States enacted these laws prior to HIPAA to address the situation in which an employer with a disabled employee or dependent switches its group health plan coverage from one issuer (the "prior carrier") to another (the "succeeding carrier"). This bulletin explains why a State succeeding-carrier law cannot eliminate the succeeding carrier's legal obligation under federal law to enroll an individual who is disabled at the time that the original health insurance coverage is terminated. However, as discussed below, this does not preclude State laws from promoting better outcomes by imposing obligations over and above the federal law requirements, or by providing rules for which carrier will actually make payment in a particular situation.[2]

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[1]The term "disabled individual," is used in this bulletin to include an individual who is receiving inpatient hospital services on the date of replacement coverage or is covered under an extension of benefits provision. Similarly, the term "disability" is used herein to refer to the state of being hospitalized on the date of replacement coverage or covered under an extension of benefits provision.

[2]For example, while under the PHS Act the legal obligation of the succeeding carrier to enroll the individual for benefits is absolute, State law might provide that another carrier has the obligation to pay for the services, so that there is no cost (or a reduced cost) to the succeeding carrier for the benefits it would otherwise be legally obligated to cover.

Because many State laws are based on the "Group Coverage Discontinuance and Replacement Model Regulation" adopted by the National Association of Insurance Commissioners (NAIC Model), this bulletin will set forth general principles based on the NAIC Model. A number of issuers and State regulators have inquired whether a State law based upon the Model is consistent with an issuer's duties to provide coverage under the PHS Act. Even if a State's law is not identical to the Model, the principles discussed here should provide useful guidance. For the reader's convenience, a copy of the NAIC's Group Coverage Discontinuance and Replacement Model Regulation is attached to this bulletin. The Model is published and copyrighted by the NAIC. Permission to reprint it here has been graciously given by the NAIC.

II. Background

A. NAIC Model.

Under the NAIC Model, when group health coverage is discontinued, the prior carrier must continue to provide benefits for a specified period of time for covered individuals who are totally disabled.[3] This obligation is the same whether or not the group health plan purchases replacement coverage.

However, if the plan obtains replacement coverage that is similar to the old coverage, section 7.B describes the extent to which the prior carrier remains liable for any extension of benefits, while section 7.C addresses the obligations of the succeeding carrier. In particular, the Model addresses the situation in which an individual was disabled at the time the plan changed carriers, and the succeeding carrier has an "actively-at-work" or "nonconfinement" clause that would preclude coverage for the disabled individual.

B. Public Health Service Act

The following provisions of the Public Health Service Act control the interaction between that federal statute and any succeeding carrier provisions that apply under State law.

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[3] Under Section 6.A of the Model, every policy or contract must provide "a reasonable provision for extension of benefits in the event of total disability at the date of the discontinuance of the group policy or contract." Section 6.D specifies that for hospital or medical expense coverages other than dental and maternity, the requirement is satisfied by an extension of at least twelve months under comprehensive or "major medical"coverages, and at least 90 days under other types of hospital or medical expense coverages. This bulletin in only concerned with the types of coverages described in Section 6.D.

1. Section 2702 of the PHS Act, 42 U.S.C. §300gg-1, states that issuers that offer coverage to group health plans "may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan" based on any of the listed "health status-related factors." The statute makes clear that disability is one of these health factors. (Section 2702(a)(1)(H).)

2. Section 2701, 42 U.S.C. §300gg, permits an issuer to impose preexisting condition exclusions for group health insurance coverage, but places substantial restrictions on that ability. In general, the exclusion:

- cannot be based on a medical condition if medical advice, etc. was not received during the six-month period before the individual became covered under the group health plan, or began a waiting period for coverage.
- cannot last longer than 12 months (or 18 months for late enrollees)
- must be reduced by creditable coverage

3. Section 2723(a) of the PHS Act, 42 U.S.C. §300gg-23(a), specifies that State laws will only be preempted under certain limited circumstances, which are discussed below.

C. Preemption – In General

"Preemption" is a term of art that refers to the situation in which Federal law supersedes State law. The courts have established guidelines for determining whether, and to what extent, State laws are preempted. The clearest indication of preemption is through the inclusion by Congress of an express preemption provision in a statute, such as in section 2723(a) of the PHS Act. That section specifies that State law will generally be preempted only if it "prevents the application of" a provision or requirement of Part A of Title XXVII. The legislative history indicates that this is intended to be the "narrowest" preemption of State laws.[4]

General case law on preemption provides additional guidance in determining what constitutes the scope of the preemption. One basis on which courts have found preemption is if compliance with both Federal and State law is, in effect, physically impossible. See Louisiana Public Service Commission v. Federal Communications Commission, 476 U.S. 355 (1986). In light of the statutory language that State law will not be preempted unless it "prevents" compliance with the

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[4] See House Conf. Rep. No. 104-736, at 205 (1996), reprinted in 1996 U.S. Code Cong. & Admin. News 2018.

PHS Act, the legislative history that indicates that preemption will be limited to the "narrowest" of circumstances, and the general case law on preemption, HCFA takes the position that State law "prevents the application" of a PHS Act provision if the State law makes it impossible for a party to comply with the PHS Act. If a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. The issuer simply could not take advantage of the State law provision.

This result is also consistent with Executive Order 13132 of August 4, 1999 (See 64 Fed. Reg. 43, 255 (August 10, 1999)), which states that "Agencies shall construe... a Federal statute to preempt State law only where the statute contains an express preemption provision or there is some other clear evidence that the Congress intended preemption of State law, or where the exercise of State authority conflicts with the exercise of Federal authority under the Federal statute."

III. Analysis

Section 7 of the NAIC Model appears to address the situation in which the succeeding carrier has an actively-at-work or nonconfinement clause that would permit the carrier to refuse to enroll a disabled individual who had been covered by the prior carrier. This provision predated the HIPAA amendments to the PHS Act, and these clauses are no longer permitted to the extent that they would deny enrollment of an individual because of a health factor. We have explained this analysis in Bulletin 00-01, with respect to nonconfinement clauses.[5] We expect future regulations to address the issue of actively-at-work provisions. However, while such provisions may be permissible in some situations, an actively-at-work provision that is used to discriminate against an individual based on a health factor, such as disability, is not permitted.[6]

Section 7.C.(1) of the NAIC Model currently states:

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[5] A nonconfinement clause generally is a plan or policy provision that delays an individual's effective date of coverage based on whether the individual is either: (1) confined to a hospital; (2) disabled; or (3) eligible for benefits under another plan's or policy's extension of benefits provision which is based on hospitalization or disability.

[6] This would include, for example, actively-at-work provisions that treat individuals on sick leave or disability leave less favorably than individuals on other types of leave.

> "Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits (in respect of classes eligible and actively at work and non-confinement rules) shall be covered by that carrier's plan of benefits."

(Emphasis added.) If the underlined words are deleted, because nonconfinement clauses and certain actively-at-work clauses are impermissible under the PHS Act, then section 7.C.(1) of the Model would appear simply to require the succeeding carrier to enroll the disabled individual and provide coverage under the regular terms of the replacement policy. This would be consistent with the PHS Act, assuming the prior carrier covered the disabling condition. It would also seem to make section 7.C.(2) inapplicable, since that section addresses the responsibilities of the prior and succeeding carriers with respect to a disabled individual who cannot satisfy an actively-at-work or nonconfinement clause.

As noted above, §2702 of the PHS Act contains an absolute legal prohibition against a carrier's refusing to enroll an otherwise eligible individual based on a disability or other health factor. As also explained above, if a State law simply permits but does not require an issuer to do something that is prohibited under the PHS Act, the State law would not be applicable. Thus if the State law purported to relieve a succeeding carrier of legal responsibility for enrolling an individual, on the basis that the individual was covered by a prior carrier under a State extension of benefits requirement, the State law would not apply.[7]

However, to the extent the State law requires coverage more extensive than required under the PHS Act, the State law could still apply. For example, in a situation that involves replacement coverage, the nondiscrimination provision of the PHS Act only applies to the succeeding carrier. Therefore, the State law obligation of the prior carrier is unaffected by the PHS Act requirement. If, for example, section 2701 of the PHS Act permitted the succeeding carrier to impose a preexisting condition exclusion on an individual's disabling condition, the prior carrier's extension of benefits obligation would presumably require it to provide coverage under State law.[8]

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[7]We believe the State law would be preempted if it prohibited the succeeding carrier from covering the individual.

[8]We are providing this example for illustration, although this situation would only occur in the unlikely event that the succeeding carrier's preexisting condition exclusion would meet all of the requirements of section 2701 of the PHS Act. (i.e., the disabling event occurred prior to the individual's enrollment date in the group health plan; the individual had been covered under the prior carrier for less than the maximum 12 months (18 months for a late enrollee); and the individual did not have enough other creditable coverage to completely eliminate the preexisting

Some States have taken the position that succeeding carrier laws simply operate as coordination of benefits provisions. We believe that this may, as a practical matter, be true when all that is at stake is which carrier pays for particular services. However, in a managed care environment we cannot agree that this is true as a legal matter. If, for example, a disabled individual was eager to switch to a provider that is only available through the succeeding carrier's network of providers, we do not believe that a State law could deny the individual the right granted by HIPAA to enroll in the succeeding carrier's coverage. We are sensitive to the fact that some States may view succeeding carrier laws as a way to protect certain disabled individuals from being suddenly required to change medical providers because of a change in carriers, where the carriers have limited provider networks. States are free to implement State requirements in a way that protects the interests of the disabled individuals without preventing the application of the federal requirement. Since 1997, the PHS Act has clearly left it within the States' authority to enforce the nondiscrimination and pre-existing condition exclusion provisions
under their own laws. Therefore in the event there is any dispute about which carrier is required to provide coverage, States have the authority to enforce the various provisions in a way that guarantees that the individual is protected.

Where to get more information:

The regulations cited in this bulletin are found in Part 146 of Title 45 of the Code of Federal Regulations (45 CFR §146). Information about the PHS Act is also available on HCFA's website at http://hipaa.hcfa.gov.

If you have any questions regarding this Bulletin, call the HIPAA Insurance Reform Help Line at (410) 786-1565 or your local HCFA Regional Office.

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condition exclusion.)