Approved: February 22, 2005
Date

MINUTES OF THE HOUSE INSURANCE COMMITTEE

The meeting was called to order by Chairman Clark Shultz at 3:30 P.M. on February 3, 2005 in Room 527-S of the Capitol.

All members were present except:
Representative Eber Phelps- excused
Representative Ray Cox- excused

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Ken Wilke, Revisor of Statutes Office
Sue Fowler, Committee Secretary

Conferees appearing before the committee:
Natalie G. Haag, Topeka, KS
Jarrod Forbes, Topeka, KS
David A. Hanson, Topeka, KS
Mike Steiner, Topeka, KS
Dan Hayden, Goodland, KS
Bill Sneed, Topeka, KS
Larry W. Magill, Topeka, KS

Others attending:
See attached list.

Representative Grant moved for a bill introduction regarding uninsured motorist coverage. Seconded by Representative B. Sharp. Motion carried.

Representative Carter moved for a bill introduction concerning model legislation and unfair insurance trade practices. Seconded by Representative Brunk. Motion carried.

Representative Carter moved for a bill introduction to draft legislation adopting NCOIL's Self Evaluating Privilege for insurance companies. Seconded by Representative McCreary. Motion carried.

Natalie G. Haag, The Security Benefit Group of Companies, requested a bill introduction regarding funding agreement asking for changes to K.S.A. 40-401, 436 and 3641 be included in one bill and the changes to K.S.A. 40-305, 306 and 502 be a part of a separate bill. Representative Grant moved for introduction of the bill. Seconded by Representative Schwab. Motion Carried.

Natalie G. Hagg, The Security Benefit Group of Companies, requested a bill introduction regarding changes to be compatible with corporate governance structure code. Representative Brunk moved for introduction of the bill. Seconded by Representative McCreary. Motion carried.

Jarrod Forbes, State Department of Insurance, (Attachment #1), requested a bill introduction that would allow the Commissioner of Insurance to have regulatory authority over plans being offered through Prescription Drug Plans. Representative Dillmore moved for introduction of the bill. Seconded by Representative B. Sharp. Motion carried.

Hearing on:

HB 2138: Amusement rides; insurance requirements.

Proponents:

MINUTES OF THE House Insurance Committee at 3:30 P.M. on February 3, 2005 in Room 527-S of the Capitol.

Representative Morrison introduced Dan Hayden, President, Sherman County Community Services, Inc., (Attachment #2), who gave testimony to endorse **HB 2138** stating the bill will spur competition in Kansas Insurance companies and based on the history of the home owned carnivals safety it will allow obtaining the kind of coverage needed.

Mike Steiner, State Department of Insurance, (Attachment #3), gave testimony in support of this **HB 2138** which is a proposal to amend K.S.A. 40-4802 and allow amusement ride operators a greater choice in purchasing insurance.

Hearing closed.

Hearing on:

HB 2161: Insurance; permitting use of inducements of $25 or less in sales of insurance.

Melissa Calderwood gave a brief overview for **HB 2161**.

Proponent:

Bill Sneed, Legislative Counsel, State Farm Insurance Companies, (Attachment #4), gave testimony in support of **HB 2161** which amends two Kansas statutes to allow some flexibility for agents throughout the State of Kansas to utilize sale inducements that re under the aggregate value of $25.00.

Opponent:

Larry W. Magill, Kansas Association of Insurance Agents, (Attachment #5), gave testimony in opposition of **HB 2161** stating rebating selects certain customers and, effectively, gives them a lower cost of insurance by virtue of the value of the inducement to buy that they receive. This isn't based on actuarial science, or on different loss characteristics of the group or on different rating factors that measure the individual insured's potential for loss but simply on whether they are perhaps targeted to receive preferential pricing.

Hearing closed.

Hearing on:

Melissa Calderwood gave a brief overview for **HB 2171**.

HB 2171: Insurance; risk-based capital requirements.

Proponents:

Jarrod Forbes, State Department of Insurance, (Attachment #6), gave testimony in support of **HB 2171** which is a proposal to amend K.S.A. 40-2c01(j), which is the definition of "RBC instructions" for life and property & casualty insurance companies.

David A. Hanson, Legislative Council for KIGA, (Attachment #7), gave testimony in support of **HB 2171** stating the NAIC does not believe there will be any substantial adverse effect from the latest revisions referred to in the Bill before you.

Hearing on:

HB 2172: Insurance agents; revocation of license.
Melissa Calderwood gave a brief overview for **HB 2172**.

Proponent:

MINUTES OF THE House Insurance Committee at 3:30 P.M. on February 3, 2005 in Room 527-S of the Capitol.

Jarrod Forbes, State Department of Insurance, (Attachment #8), gave testimony in support of **HB 2172** which is a proposal to amend K.S.A. 40-246d by removing the reference of 40-246 and replace it with 40-4909. K.S.A. 40-246 no longer exists, and 40-4909 along with 40-241 are now the appropriate statutes for insurance agent license revocation.

Hearing closed.

Next meeting will be Tuesday, February 8, 2005.

Meeting adjourned at 4:50 p.m.

House Insurance Committee
Guest Sign Sheet
Thursday, February 3, 2005

Name	Representing
Natalie Haag	Security Benefit
Larry Magill	KAIA
Daniel Mauer	KAIA
Lee Wright	FARMERS
Bill Sneed	State Farm
Cheryl Dillard	Coventry Health Care
David Hanson	KS Insur Assns
Rick Wilson	Farmers Alliance
Ron Stamey	SFC
Alex Kotoyantz	PIA
Chris Alpers	Foster (Eric Carter)
Ron Seeber	Hein law Firm
Judy Braden	KAIFA

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

KANSAS INSURANCE DEPARTMENT
LEGISLATIVE REQUESTS
HOUSE COMMITTEE ON INSURANCE
February 3, 2005

Mr. Chairman and members of the committee:

Thank you for the opportunity to appear before you on behalf of the Kansas Insurance Department. Today I respectfully request the introduction of a committee bill. For your convenience, I have attached the proposed language to my testimony.

The Kansas Prepaid Limited Health Service Organization Act would allow the Commissioner of Insurance to have regulatory authority over plans being offered through Prescription Drug Plans (PDP) established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Essentially this would allow our department to assist consumers in the same way we currently do for all other types of insurance products. Clearly, we will provide more detailed testimony at the appropriate time.

With that, Mr. Chairman, I respectfully request this legislation be introduced as a committee bill and would be happy to stand for any questions you may have.

Jarrod Forbes
Assistant Director
Government Affairs
Kansas Insurance Department

House Insurance
Date: 2-3-05
Attachment # 1

420 SW 9TH STREET
TOPEKA, KANSAS 66612-1678

PHONE 785.296.3071
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CONSUMER HOTLINE
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LIMITED HEALTH SERVICE ORGANIZATIONS

Short Title

This Act may be cited as the "Limited Health Service Organization Act of Kansas"

Definitions

As used in this Act, unless otherwise defined in this Act:

(a) "Commissioner" means the Commissioner of Insurance of the State of Kansas.

(b) "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

(c) "Evidence of coverage" means the certificate, agreement or contract issued pursuant to Section 9 of this Act setting forth the coverage to which an enrollee is entitled.

(d) "Limited health service" means pharmaceutical services, dental care services, vision care services, mental health services, substance abuse services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical or emergency services except as these services are provided incident to the limited health services set forth in the preceding sentence.

(e) "Limited health service organization" means any corporation, partnership or other entity that, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. limited health service organization does not include:

(1) An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;

(2) An entity that meets the requirements of Section 7 of this Act; or

(3) A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a limited health service organization or with an entity described in Paragraph (1) or (2) of this definition.

(f) "Provider" means a physician, dentist, health facility, or other person or institution that is licensed or otherwise authorized to deliver or furnish limited health services.

(g) "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this Act.

Certificate of authority required; application;

(a) No person, corporation, partnership or other entity may operate a limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this Act.

(b) An application for a certificate of authority to operate a limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(1) A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents and all amendments to these documents;

(2) A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association;

(4) A statement generally describing the applicant, its facilities, personnel and the limited health services to be offered;

(5) A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees;

(6) A copy of the form of any contract made, or to be made between the applicant and any person listed in Subsection C of this section;

(7) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and subcontracting for the provision of limited health services to enrollees;

(8) A copy of the form of any group contract that is to be issued to employers, unions, trustees or other organizations and a copy of any form of evidence of coverage to be issued to subscribers;

(9) A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidating financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this Act;

(10) A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(11) A schedule of rates and charges;

(12) A description of the proposed method of marketing;

(13) A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with K.S.A. 40-218 and amendments thereto;

(14) A description of the complaint procedures to be established and maintained as required under this Act;

(15) A description of the quality assessment and utilization review procedures to be utilized by the applicant;

(16) A description of how the applicant will comply with the solvency provisions of this act;

(17) The fee for issuance of a certificate of authority, as provided in this act; and

(18) Such other information as the commissioner may reasonably require to make the determinations required by this Act.

(c) The commissioner may promulgate rules and regulations the commissioner deems necessary to the proper administration of this act to require a limited health service organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (b) to the commissioner prior to the effectuation of the modification or amendment or to require the limited health service organization to indicate the modifications to the commissioner.

(d) Any modification or amendment for which the approval of the commissioner is required shall be deemed approved unless disapproved within 30 days, except the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.

Issuance of Certificate of Authority; Denial

(a) Following receipt of an application filed pursuant to this act, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:

(1) The requirements of this act have been fulfilled;

(2) The individuals responsible for conducting the applicant's affairs are competent, trustworthy and possess good business reputations, and have had appropriate experience, training or education;

(3) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:

(A) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments and other patient charges used in connection therewith;

(B) The adequacy of working capital, other sources of funding, and provisions for contingencies;

(C) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the limited health service organization; and

(D) The manner in which the solvency requirements of this Act have been fulfilled;

(4) The agreements with providers for the provision of limited health services contain the provisions required by this Act; and

(5) Any deficiencies identified by the commissioner have been corrected.

(b) If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The limited health service organization shall have fifteen (15) days from the date of receipt of the notice to request a hearing before the commissioner in accordance with the provisions of the Kansas administrative procedure act.

Effect on Organizations Operating on Effective Date of this Act

Within sixty (60) days after the effective date of this Act, every limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a limited health service organization whose certificate of authority has been revoked.

Filing Requirements for Authorized Entities

(a) An entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital or medical service corporation or a fraternal benefit society and that is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by this act and any subsequent material modification or addition thereto.

(b) If the commissioner disapproves the filing, the procedures set forth in this act shall be followed.

Changes in Rates and Benefits, Material Modifications; Addition of Limited Health Services

(a) A limited health service organization shall file with the commissioner prior to use, a notice of any change in rates, charges or benefits and of any material

modification of any matter or document furnished pursuant to this act, together with supporting documents necessary to fully explain the change or modification. If the commissioner does not disapprove the filing within thirty (30) days of its filing, the filing shall be deemed approved.

(b) If a limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by this act (if different from that filed with the limited health service organization's application), and shall demonstrate compliance with the Provider Contracts, Solvency, and Fees sections of this act. If the commissioner does not disapprove the filing within thirty (30) days of its filing, the filing shall be deemed approved.

(c) If such filings are disapproved, the commissioner shall notify the limited health service organization and shall specify the reasons for disapproval in the notice. The limited health service organization shall have fifteen (15) days from the date of receipt of notice to request a hearing before the commissioner in accordance with the Kansas administrative procedure act.

Evidence of Coverage

(a) Every subscriber shall be issued an evidence of coverage, which shall contain a clear and complete statement of:

(1) The limited health services to which each enrollee is entitled;

(2) Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment or other charges;

(3) Where and in what manner information is available as to where and how services may be obtained; and

(4) The method for resolving complaints.

(b) Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

Rates and Charges

The rates and charges shall be reasonable in relation to the services provided. The commissioner may request information from the limited health service organization supporting the appropriateness of the rates and charges.

Construction with Other Laws

(a) (1) A limited health service organization organized under the laws of this state shall be deemed to be a domestic insurer for purposes of K.S.A. 40-3301, et seq., unless specifically exempted in writing from one or more of the provisions of that act by the commissioner.

(2) A limited health service organization shall be subject to the provisions of the Kansas regulation of trade practices act, K.S.A. 40-2402, et seq.

(3) No other provision of the insurance code shall apply to a limited health service organization unless such an organization is specifically mentioned therein.

(b) The provision of limited health services by a limited health service organization or other entity pursuant to this Act shall not be deemed to be the practice of medicine or other healing arts.

(c) Solicitation to arrange for or provide limited health services in accordance with this Act shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

Nonduplication of Coverage

Notwithstanding any other law of this state, a limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services (whether in the form of services, supplies or reimbursement), insofar as the coverage or service is provided in accordance with this Act under a contract or policy issued to the same group or to a part of that group by a limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation or a fraternal benefit society.

Grievance procedures; minimum requirements

A limited health service organization shall provide in its certificate of coverage the procedures for resolving enrollee grievances. At a minimum, the certificate of coverage shall include the following provisions:

(a) The definition of a grievance;

(b) how, where and to whom the enrollee should file such enrollee's grievance; and

(c) that upon receiving notification of a grievance related for payment of a bill for services, the limited health service organization shall:

(1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;

(2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. Every limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein shall be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

Examination of Organization

(a) The commissioner may examine the affairs of any limited health service organization as often as is reasonably necessary to protect the interests of the people of this state, but not less frequently than once every three (3) years.

(b) Every limited health service organization shall make its relevant books and records available for an examination and in every way cooperate with the commissioner to facilitate an examination.

(c) The reasonable expenses of an examination under this section shall be charged to the organization being examined and remitted to the commissioner.

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

Investments

With the exception of investments made in accordance with other provisions of this act, the investable funds of a limited health service organization shall be invested only in securities or other instruments permitted by article 2a of chapter 40 of the Kansas Statutes annotated, or acts amendatory thereof or supplemental thereto, or such other securities or investments as the commissioner may permit.

Agents

No individual may apply, procure, negotiate or place for others any policy or contract of a limited health service organization unless that individual holds a license or is otherwise authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

Contracts with Providers

All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis shall contain or shall be construed to contain the following terms and conditions:

(a) In the event the limited health service organization fails to pay for limited health services for any reason whatsoever, including but not limited to, insolvency or breach of contract, the enrollees shall not be liable to the provider for any sums owed to the provider under the contract.

(b) No provider, agent, trustee or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the limited health service organization.

(c) These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.

(d) These provisions shall survive the termination of the contract, regardless of the reason giving rise to termination.

(e) Termination of the contract shall not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed 30 days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of the contract.

(f) Any amendment to these foregoing provisions of the contract must be submitted to and be approved by the commissioner prior to becoming effective.

Deposit requirements; waiver of deposit; plan for continuation of benefits following insolvency

(a) Except as provided in paragraph (f), before issuing any certificate of authority, the commissioner shall require that the limited health service organization have an initial net worth of $1,500,000, of which $750,000 shall be met by cash or cash equivalents, and shall thereafter maintain such minimum net worth of $1,500,000.

(b) For the purpose of this section, "minimum net worth" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner. "Net worth" means net equity reduced by the value assigned to intangible assets including, but not limited to, goodwill; going concern value; organizational expense; starting-up costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of

officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates and that are not past due. "Cash or cash equivalents" means those current assets that can be converted to cash in one year or less.

(c) Unless otherwise provided below, each limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures, for the benefit of all of the enrollees of the limited health service organization, that are acceptable in the amount of one hundred thousand dollars ($100,000.00).

(d) The deposit shall be an admitted asset of the limited health service organization in the determination of tangible net equity.

(e) All income from deposits shall be an asset of the limited health service organization. A limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(4) The deposit shall be used to protect the interests of the limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a limited health service organization that is in rehabilitation or conservation. If a limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.

(5) The commissioner may reduce or eliminate the deposit requirement if the limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

(f) The commissioner may waive any of the requirements set forth in subsections (a) through (e) whenever satisfied that: (1) The organization has sufficient net worth and/or an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

(g) The commissioner shall require that each limited health service organization have a plan for handling insolvency which allows for continuation of coverage/benefits for the duration of the contract period.

(h) The health organization risk-based capital requirements, as stated in K.S.A. 40-2d01, *et seq*., shall not apply to any limited health service organization contracting for services provided under Title XIX, XXI, or XVIII of the Social Security Act or any other public benefits, provided the public benefit contracts represent at least 90% of the premium volume of the limited health service organization.

Funding for Projected Losses

A limited health service organization shall demonstrate that it has the assets available to meet any projected losses. The assets required under this section may be satisfied by assets and/or other arrangements acceptable to the commissioner, including parental guarantees and letters of credit.

Officers and Employees Fidelity Bond

A. A limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $175,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a surplus lines agent resident in this state and licensed in compliance with K.S.A. 40-246b, shall satisfy the requirements of this subsection.

Reports

(a) Every limited health service organization shall file with the commissioner annually, on or before April 1, a report verified by at least two principal officers covering the preceding calendar year.

(b) The report shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the organization, including its balance sheet, income statement and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which shall be consolidating financial statements of the limited health service organization;

(2) The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year; and

(3) Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out his or her duties under this Act.

(c) The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out his or her duties under this Act.

(d) The commissioner may assess a fine of up to $100 per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

Suspension or Revocation of Certificate of Authority

(a) The commissioner may suspend or revoke the certificate of authority issued to a limited health service organization pursuant to this Act upon determining that any of the following conditions exist:

(1) The limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The limited health service organization issues an evidence of coverage or uses rates or charges that do not comply with the requirements of this Act.

(3) The limited health service organization is unable to fulfill its obligations to furnish limited health services;

(4) The limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(5) The tangible net equity of the limited health service organization is less than that required by this act or the limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner;

(6) The limited health service organization has failed to implement in a reasonable manner the complaint system required by this Act;

(7) The continued operation of the limited health service organization would be hazardous to its enrollees; or

(8) The limited health service organization has otherwise failed to comply with this Act.

(b) If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with the procedures of the Kansas administrative procedure act.

(c) When the certificate of authority of a limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

Penalties

In lieu of any penalty specified elsewhere in this Act, or when no penalty is specifically provided, whenever a limited health service organization or other person, corporation, partnership or entity subject to this Act has been found, pursuant to the procedures of the Kansas administrative procedure act to have violated any provision of this Act, the commissioner may:

(a) Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of the findings and an order requiring the organization, person or entity to cease and desist from engaging in the act or practice that constitutes the violation; and

(b) Impose a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000.

Rehabilitation, Conservation or Liquidation

(a) Any rehabilitation, conservation or liquidation of a limited health service organization shall be deemed to be the rehabilitation, conservation or liquidation

of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation liquidation or conservation of insurance companies.

(b) A limited health service organization shall not be subject to the laws and regulations governing insurance insolvency guaranty funds, nor shall any insurance insolvency guaranty fund provide protection to individuals entitled to receive limited health services from a limited health service organization.

Fees

Every limited health service organization subject to this Act shall pay to the commissioner the following fees:

(a) For filing an application for a certificate of authority, $150;

(b) For filing an amendment to the certificate of authority, $10;

(c) For filing each annual report, $50.

Confidentiality

(a) Any information pertaining to the diagnosis, treatment or health of any enrollee obtained from the person or from a provider by a limited health service organization and any contract with providers submitted pursuant to the requirements of this Act shall be held in confidence and shall not be disclosed to any person except:

(1) To the extent that it may be necessary to carry out the purposes of this Act;

(2) Upon the express consent of the enrollee or applicant, provider or limited health service organization, as appropriate;

(3) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(4) In the event of claim or litigation wherein the data or information is relevant.

(b) With respect to any information pertaining to the diagnosis, treatment or health of any enrollee or applicant, a limited health service organization shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the limited health service organization is entitled to claim.

(c) In addition, any information provided to the commissioner that constitutes a trade secret, as defined in K.S.A. 60-3320, et seq., is privileged information, or is part of a department investigation or examination shall be held in confidence.

Taxes

A limited health service organization shall be deemed an insurance company and shall subject to the same taxes and fees imposed upon insurance companies and entitled to the same tax deductions, reductions, abatements, and credits that insurance companies are entitled to receive.

Severability

If any section, term or provision of this Act shall be adjudged invalid for any reason by a court of competent jurisdiction, the judgment shall not affect, impair or invalidate any other section, term or provision of this Act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Regulations

The commissioner may, after notice and hearing, promulgate regulations to carry out the provisions of this Act.

Effective Date

The effective date of this Act shall be July 1, 2005.

Good afternoon my name is Daniel Hayden I am President of Sherman County Community Services Inc. the home owned carnival for Goodland, KS. I am here to endorse House bill no. 2138. As you are probably all are aware the home owned carnivals have been faced with a great financial burden of wanting to obtain good quality insurance. Currently our policies are being written by carriers outside of the state of Kansas and every year we have to find a new company to write the policy. Prices have increased dramatically (see attached) it has reached a point that we will no longer be able to afford insurance to operate. No one wants that. In October of last year we met in Colby Kansas with several area carnivals and all agreed that we want to purchase good quality insurance at an affordable cost. I would like to read a statement from Thomas County. (read statement) I also have spoken to Gary Kay of the Rush County Amusement association and he also is in support of this bill. It is note worthy that he does bring up a concern that this bill states that insurance must be written by a Kansas company and what happens if no Kansas company will write the policy.

I feel that this bill will spur competition in Kansas Insurance companies and based on the history of the homeowned carnivals safety it will allow us to obtain the kind of coverage we all want. Good affordable coverage.

Thank you

House Insurance
Date: 2-3-05
Attachment # 2

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON
HB 2138 – AN ACT CONCERNING AMUSEMENT RIDES
HOUSE COMMITTEE ON INSURANCE
February 3, 2005

Mr. Chairman and members of the committee:

Thank you for the opportunity to speak with you today. HB 2138 is a proposal to amend K.S.A. 40-4802 and allow amusement ride operators a greater choice in purchasing insurance.

Under current law, an amusement ride operator in Kansas is required to purchase insurance for liability and bodily injury from an insurance company authorized to do business in Kansas. At this time, no authorized insurance company in Kansas offers the necessary commercial general liability insurance to amusement ride operators required by state law.

HB 2138 would amend K.S.A. 40-4802 to allow amusement ride operators to purchase insurance written by a company doing business in Kansas. Under current law, an amusement ride operator may purchase insurance only from an authorized or admitted carrier, not a non-admitted carrier. This change would allow amusement ride operators to purchase insurance from an admitted or non-admitted carrier.

Thank you for the opportunity to appear before your committee. I would be happy to answer any questions.

Michael Steiner
Legislative Liaison

House Insurance
Date: 2-3-05
Attachment # 3

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Memorandum

TO: THE HONORABLE CLARK SHULTZ
CHAIRMAN, HOUSE INSURANCE COMMITTEE

FROM: WILLIAM W. SNEED, LEGISLATIVE COUNSEL
THE STATE FARM INSURANCE COMPANIES

RE: H.B. 2161

DATE: FEBRUARY 3, 2005

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for The State Farm Insurance Companies. State Farm is the largest insurer of homes and automobiles in the United States and in Kansas. State Farm insures one out of every five cars and one out of every four homes in the United States.

On January 7, 2005, at our request, this Committee introduced H.B. 2161. As stated in our request, this bill amends two Kansas statutes to allow some flexibility for agents throughout the State of Kansas to utilize sale inducements that are under the aggregate value of $25.00.

In many instances, my client has appeared before this Committee requesting proposals that are generated from our corporate offices as they relate to the current state of the insurance world. This bill is a direct request from our agency force, who has found the current prohibition cumbersome and outdated in today's world. It is important to note that our agents are independent contractors, and even though such a program would "cost" them money, our agent population feels strongly that such an exception should be allowed in order to assist them in the marketplace.

Every state has a rebating law. These laws are usually a part of the Unfair Claims Practices Act. They have been instituted throughout the country in order to preserve the appropriate "rate" attached to whatever policy is being sold to the consumer. It is important to note that most laws, like the Kansas law, were put in place to make certain that the premium paid by the consumer is adequate not only from the standpoint of not being excessive in charges, but also to assure that it is not inadequate to cover the appropriate costs. If the rates were inappropriately discounted, an insurer might found itself out in the marketplace selling hundreds

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of thousands of dollars of premium, but when the claims came due, would not have adequate resources to pay the claims.

This amendment allows for a small margin of decrease that really has nothing to do with the premium, but has everything to do with the agent's ability to use his or her money in appropriate fashion to solicit customers. Again, it is important to note that any utilization of this program would come out of the pockets of the agents and not from the premiums submitted to the company, which ultimately is there to provide for the payment of claims.

Although we do not have an exhaustive review, we were able to confirm exceptions to rebating laws in the following nine states:

- Missouri: bulletin issued by the Insurance Department established a $25.00 exemption
- Kentucky: statutory $25.00 exemption
- New Jersey: statutory $20.00 exemption
- Oklahoma: statutory $25.00 exemption
- Utah: statutory $3.00 exemption
- Nevada: bulletin allows exemption with the prior approval of DOL
- Arizona: statutory $10.00 exemption
- Illinois: statutory exemption for a gift certificate for a child passenger seat
- Maryland: statutory exemption for education, promotional materials or articles of merchandise that cost less than $10.00

As you can see from this list, our agents in Kansas directly compete against agents in Missouri and Oklahoma. It is their belief (and they are willing to pick up the tab) that an exception like this would benefit their ability to attract customers, and at the same time, provide some unique marketing tools to potential customers.

For instance, our company has seen programs where agents offer a new set of washer hoses to potential customers. Water damage done by broken washing machine hoses is one of the leading damage components in homeowners' insurance today. Additionally, we have offered atlases to our automobile customers. Relating to our life products, agents have utilized letters of congratulations to new parents and offered a $10.00 gift certificate to Babies R Us.

Our bill is modeled on the Oklahoma statute. The statute is easy to administer and understand. Secondly, by limiting the exception to tangible goods, merchandise and certificates, the issue of large-scale rebating is eliminated. In fact, the rebating statute found at K.S.A. 40-966 is left untouched.

Although the bill is lengthy, the changes are very slight. First, on page one, line 24, a new cross-reference is included to the amendment that is found later in the bill at K.S.A. 40-2404. That amendment, and the really meat of the bill, is found on page 11, lines 28-34.

We believe this bill provides a marketing tool that is necessary in today's arena. At the same time, it continues to protect the integrity of rates and does not endanger the fundamental issues of the insurance rating practice.

Finally, it is again important to recognize that this change is being sought by our agents, who are willing to utilize the program with their own funds in an effort to continue to compete in today's marketplace.

Thus, based upon the foregoing, we respectfully request that when the Committee reviews this bill, it act favorably and recommend H.B. 2161 for passage. I would be happy to answer any questions or discuss this further at your convenience.

Respectfully submitted,

William W. Sneed

WWS
Attachment

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Testimony on HB 2161
Before the House Insurance Committee
By Larry Magill
Kansas Association of Insurance Agents
February 3, 2005

Thank you Mister Chairman and members of the committee for the opportunity to appear today in opposition to House Bill 2161 that would undermine Kansas' anti-rebating statute. I am Larry Magill representing the Kansas Association of Insurance Agents. KAIA was formed in 1992 by the merger of the Independent Insurance Agents of Kansas and the Professional Insurance Agents of Kansas, but our roots go back to 1920. We represent 425 independent agencies with 150 branch locations and approximately 2,500 employees. Most of the employees in our member agencies are licensed agents since they will have some client contact.

House Bill 2161 seeks to amend law that was first established around 1927 and has not been substantively amended since. If fact, it was reenacted without changes in 1997 when the new fire and casualty rating law was enacted. KSA 40-966 prohibits what is commonly referred to as rebating, that is offering any kind of inducement outside of the filed rates and rating plans of an insurer to someone to cause them to buy insurance from the agent or insurance company. While this statute, KSA 40-966, deals with property and casualty insurance, the unfair trade practices act, 40-2404, that is also amended by this proposal also prohibits rebating in life, health and title insurance. In fact, rebating has been prohibited at least since 1927 in all lines of insurance. The main reason is that it is inherently discriminatory and often done "under the table".

Rebating selects certain customers and, effectively, gives them a lower cost of insurance by virtue of the value of the inducement to buy that they receive. This isn't based on actuarial science, or on different loss characteristics of the group or on different rating factors that measure the individual insured's potential for loss but simply on whether they are perhaps targeted to receive preferential pricing.

Kansas law has always favored giving everyone the best price possible and not just those an insurer or their agent wants to give an incentive to this week. We question why the proponents of this legislation do not simply lower their rates by up to $25 for all of a given class of insured if they have some "fat" in their rates, as they apparently do. That would be the fair and equitable approach in our opinion. Or they could declare a dividend if the policies have been filed under a plan that allows that. With a dividend approach, they can wait to see what their claims and profit experience is before declaring the dividend. That has the added benefit of encouraging customers to stay with them. If I'm not mistaken, the proponents have the ability to declare dividends as a mutual insurer and have done so in the past.

We suspect you will hear about Farm Bureau's ability to offer member benefits to it's customers but remember that they have to charge every insured $25 to $35 to join Farm Bureau and for their membership dues they receive benefits. Just as you can join

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AARP, if you are old enough, buy their insurance and receive their member benefits including discounts. But they are a legitimate association aside from marketing insurance products. You must pay separately for the association member benefits you receive. Frankly, I would rather not have to sell a separate member dues payment in addition to the cost of the insurance. That seems like more of a competitive disadvantage, than advantage.

While HB 2161 only puts a small hole in the anti-rebating principal, it is nevertheless a hole. And such "holes" have a tendency to grow over time. If rebating is wrong, if rebating is discriminatory, if rebating leads to under the table deals that benefit the few at the expense of the many, then a little rebate is as bad as a large rebate.

We assume that this will become like our speed limits where everyone knows that they will be stretched at least 9 miles per hour over the legal limit. How much more than $25 will be allowed in this case? What if the insurer alleges that the item being given away didn't cost them anything? Maybe if they buy enough toasters the supplier will throw in the microwaves for free.

We think it's a slippery slope the legislature is being asked to start down and urge you not to take that first step. We urge the committee to not pass this bill out.

We would be happy to respond to questions or provide additional information. Thank you for your time and attention to this issue.

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS
ON
HB 2171—RISK BASED CAPITAL REQUIREMENTS
HOUSE COMMITTEE ON INSURANCE
February 3, 2005

Mr. Chairman and members of the committee:

Thank you for the opportunity to visit with you on behalf of the Kansas Insurance Department. This bill is a proposal to amend K.S.A. 40-2c01(j), which is the definition of "RBC instructions" for life and property & casualty insurance companies.

Risk-based capital (RBC) is a method that has been used by the Kansas Insurance Department since the mid 1990's to evaluate the financial solvency of insurance companies doing business in this state. The RBC statutes also prescribe various forms of regulatory action that may be taken, or shall be taken, in the event that a company's calculated RBC meets certain thresholds.

Companies must file financial reports with the Department using RBC instructions and formulas developed by the National Association of Insurance Commissioners (NAIC). These instructions, including the formulas, are amended each year to address various matters, such as changes to line references in the annual statement blanks and to reflect any necessary modifications or adjustments to the formulas.

The current law requires companies to use the December 31, 2003 version of the "RBC instructions". This bill would reflect a change in the date of the standard so that companies would use the "RBC instructions", including the formulas, in effect as of December 31, 2004.

Thank for the opportunity to speak today I would be happy to stand for any questions the committee may have.

Jarrod Forbes
Assistant Director
Government Affairs

House Insurance
Date: 2-3-05
Attachment # 6

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Kansas Association of Property & Casualty Ins. Cos.

Member Companies:

Armed Forces Insurance Exchange
Ft. Leavenworth

Bremen Farmers Mutual Insurance Co.
Bremen

Columbia Insurance Group
Salina

Farm Bureau Mutual Insurance Company
Manhattan

Farmers Alliance Mutual Insurance Company
McPherson

Farmers Mutual Insurance Co.
Ellinwood

Federated Rural Electric Insurance Exchange
Lenexa

Kansas Mutual Insurance Co.
Topeka

Marysville Mutual Insurance Co.
Marysville

Mutual Aid Association of the Church of the Brethren
Abilene

Mutual Aid eXchange
Overland Park

Upland Mutual Insurance Co.
Chapman

Kansas Life Insurance Association

Member Companies:

The American Home Life Insurance Company
Topeka

American Investors Life Insurance Company
Topeka

Blue Cross/Blue Shield of Kansas
Topeka

Employers Reassurance Corporation
Overland Park

First Life America Corporation
Topeka

Preferred Health Systems
Wichita

The Pyramid Life Insurance Company
Shawnee Mission

Security Benefit Life Insurance Company
Topeka

House Insurance Committee
Testimony on House Bill 2171

February 2, 2005

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present information on behalf of the Kansas Association of Property and Casualty Insurance Companies and the Kansas Life Insurance Association, whose members are domestic insurance companies in Kansas.

The risk-based capital provisions referenced in the Bill were developed by the NAIC for adoption and use by the states as a standardized method of monitoring the solvency of insurers and assessing the need for corrective action. The reference date in the statutory definition of "RBC instructions" was originally requested to make sure that the adopted instructions and formula were limited to those that we had had an opportunity to review, rather than potential future revisions, which could adversely affect our companies' risk-based capital evaluation and the resulting action or control levels. While we believe our companies remain in good standing under the previously adopted NAIC instructions and formula, we also believe any significant changes in those instructions and formula by the NAIC should be carefully considered before adoption in Kansas.

At this point, we do not believe there will be any substantial adverse effect from the latest revisions referred to in the Bill before you. Thank you for your consideration.

Respectfully,

David A. Hanson

DAVID A. HANSON

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House Insurance
Date: 2-3-05
Attachment # 7

Kansas
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Sandy Praeger COMMISSIONER OF INSURANCE

HB2172

COMMENTS
ON
HB 2172—INSURANCE AGENTS; REVOCATION OF LICENSE
HOUSE COMMITTEE ON INSURANCE
February 3, 2005

Mr. Chairman and members of the committee:

Thank you for the opportunity to visit with you on behalf of the Kansas Insurance Department. This bill is a proposal to amend K.S.A. 40-246d by removing the reference of 40-246 and replace it with 40-4909. K.S.A. 40-246 no longer exists, and 40-4909 along with 40-241 are now the appropriate statutes for insurance agent license revocation.

Thank for the opportunity to speak today I would be happy to stand for any questions the committee may have.

Jarrod Forbes
Assistant Director
Government Affairs

House Insurance
Date: 2-3-05
Attachment # 8

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