Approved: March 31, 2005
Date

MINUTES OF THE SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

The meeting was called to order by Chairman Ruth Teichman at 9:30 A.M. on March 17, 2005 in Room 234-N of the Capitol.

All members were present.

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

Conferees appearing before the committee:
Jarrod Forbes, Kansas Insurance Department
Brad Smoot, Blue Cross Blue Shield of Kansas City
Ron Gaches, First Data Corporation
William Sneed, State Farm Insurance Companies
Brad Smoot, American Insurance Associations
David Hanson, Kansas Association of Property & Casualty Insurance Companies and Kansas Life & Health Insurance Association
Jim Hall, American Council of Life Insurers
Richard Wilborn, Farmers Alliance
Larrie Ann Lower, Kansas Association of Health Plans
Jeff Kniep, Kansas Action Network
Terry Humphrey, Kansas Trial Lawyers Association
Jacob S. Graybill, Patterson, Gott & Graybill, LC
Barb Hinton, Kansas Legislative Division of Post Audit

Others attending:
See attached list.

Madam Chair called the meeting to order.

Madam Chair opened the hearing on **HB 2203**.

HB 2203 - Medical and hospital service corporations; termination of coverage for cause approved by commissioner of insurance

Terry Weber, Kansas Legislative Research Department, presented an overview on **HB 2203**. **HB 2203** would amend K.S.A. 40-92306 which concerns nonprofit medical and hospital service corporations. **HB 2203** would add language that permits nonprofit medical and hospital services corporations to cancel health insurance policies without offering continuation coverage. The original language did not include Blue Cross and Blue Shield of Kansas City. This bill would remedy the inconsistencies. There is no fiscal effect. **HB 2203** passed the House with a 122 to 0 vote.

Jarrod Forbes, Kansas Insurance Department, testified in behalf of **HB 2203.** **HB 2203** would allow a nonprofit medical and hospital service corporation to cancel a policy for "cause" such as fraud. (Attachment 1)

Ken Wilke, Officer of Revisor of Statutes, asked if the types of cause that are permitted, going to be set forth in any rules and regulations? Craig VanAalst stated his that it was his understanding it would be in fraud and misrepresentation.

Brad Smoot, Blue Cross Blue Shield of Kansas City, testified in support of **HB 2203**. (Attachment 2)

There were no further questions.

Madam Chair closed the hearing on **HB 2203**.

MINUTES OF THE Senate Financial Institutions and Insurance Committee at 9:30 A.M. on March 17, 2005 in Room 234-N of the Capitol.

Madam Chair opened the hearing on **HB 2276**.

HB 2276 - Transmission of money charges

Melissa Calderwood, Kansas Legislative Research Department, presented an overview of **HB 2276**. The House Committee recommended a substitute for **HB 2276** which would allow new law providing a person complying with the provision of K.S.A. 9-508 through 9-513 and the amendments thereto may charge a different price for a transmission of money. **HB 2276** would provide that the charges are based upon the mode of transmission, use of the transaction and that the price charged for the services are identical for all forms of attainment accepting the same mode of transmission. **HB 2276** was brought to the committee by Western Union. The bill was amended as a substitute to be related only to the mode of transmission.

Ron Gaches, First Data Corporation/Western Union, testified in support of **HB 2276**. The bill is intended to provide that Western Union and other money transmitters may charge a different price for internet or phone ordered money transmissions as opposed to the walk-up price. (Attachment 3)

Senator Barone asked why do we need this bill? Mr. Gaches said Kansas is one of eleven states that have a credit card surcharge act which provides that the price of goods or service purchases shall be the same as the price of goods or services paid for by cash. So charging a different price for a service that is paid for by credit card is in violation of Kansas statute. Senator Barone stated that Ron's explanation about credit cards is covered in the bill, so why do we need this? Mr. Gaches said that the intent of the bill is to make it clear those money transmitters providing that service would be allowed to charge a price different from the walk-up price. Senator Barone asked that Ken Wilke, Advisor of Statutes, take a look at this issue.

There were no other questions.

Madam Chair closed the hearing on **HB 2276**.

Madam Chair opened the hearing on **HB 2357**.

HB 2357 - Establishing a self audit program for insurance

Melissa Calderwood, Department of Research, presented an overview on **HB 2357**. **HB 2357** is a new law related to self audits conducted by insurance companies. There are a number of provisions in this bill which would include making an insurance client's self evaluated audit privileged information and therefore not subject to discovery or admissible as evidence in any civil, criminal or administrative procedure. **HB 2357** was requested by the House Insurance Committee by Representative Carter.

Bill Sneed, The State Farm Insurance Companies, testified in support of **HB 2357**. There must be an insurance compliance audit. Audits may not be allowed to hide illegal or improper activities. The privilege does not apply to preexisting materials. On page 4, line 39 would cover this. The intent of the definition of a self evaluated audit document is that those documents that are generated from that audit would garner the privilege. (Attachment 4)

Brad Smoot, American Insurance Association, testified in support of **HB 2357**. Mr. Smoot stated Kansas has numerous laws that shield various types of information from court action. (Attachment 5)

Dave Hanson, Kansas Association of Property & Casualty Insurance Companies and the Kansas Life & Health Insurance Association, testified in support of **HB 2357**. (Attachment 6)

Jim Hall, American Council of Life Insurers, testified in support of **HB 2357**. Mr. Hall focused on the life insurance side of this bill. (Attachment 7)

Richard Wilborn, Farmers Alliance, testified in support of **HB 2357**. (Attachment 8)

Larrie Ann Lower, Kansas Association of Health Plans, briefly testified in support of **HB 2357** stating she

agreed with all the previous speakers and offered her written testimony to the committee. (Attachment 9)

Jeff Kniep, Kansas Action Network, testified in opposition of **HB 2357**. Business ethics and corporate compliance are under extensive scrutiny for very good reasons. Fraud is fraud, and it should be dealt with accordingly. (Attachment 10)

Terry Humphrey, Kansas Trial Lawyers Association, testified in opposition of **HB 2357**. Ms. Humphrey stressed to the Committee that **HB 2357** creates an absolute privilege for self evaluative audits which are performed by insurers on their own business activities and their compliance with state and federal law. As a result self evaluative audits any documents related to that audit are undiscoverable and inadmissible in court of law in administrative and civil proceedings. They are not subject to production under the Open Records Act. Ms. Humphrey also attached two articles relating to her testimony. (Attachment 11)

Jacob Graybill, Patterson, Gott & Graybill, LC, testified in opposition of **HB 2357**. (Attachment 12) Mr. Graybill's opposition on this bill is based on its intention to facilitate misconduct. The concern is about renegade management, pillaging the assets of the insurance companies. Mr. Graybill also handed out material that he referred to in which to support his testimony. (Attachment 13)

Barb Hinton, Legislative Division of Post Audit, had written testimony, taking a neutral position on **HB 2357**. (Attachment 14) Chair Teichman handed out a balloon amendment that addresses post audit. (Attachment 15)

Madam Chair announced that the Committee would be meeting March 21.

The meeting was adjourned.

FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST
DATE: Thurs. March 17

NAME	REPRESENTING
Jim Hacc	American Council of Life Insurers
Alex Kotoyantz	P.I.A.
David Hanson	Ks Ins Assns & PCI
Brad Smoot	AIA
[illegible]	KID
Sonya Allen	OSBC
Natalie Haag	Security Benefit
Kevin Barde	KTLA
Craig Van Aalst	KID

Kansas
Insurance
Department

Sandy Praeger COMMISSIONER OF INSURANCE

COMMENTS ON
HB 2203—CONCERNING NONPROFIT MEDICAL AND HOSPITAL SERVICE CORPORTATIONS
SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE
March 17, 2005

Madam Chair and members of the committee:

Thank you for the opportunity to visit with you on behalf of the Kansas Insurance Department. House Bill 2203 would allow a nonprofit medical and hospital service corporation to cancel a policy for "cause" such as fraud.

For years the HMO's have had the ability to cancel for reasons of "cause". Last year we intended to include all other organizations writing health policies in Kansas by amending the insurance law with language contained in HB 2597. However, the particular statute we amended does not include Blue Cross Blue Shield of Kansas City for the simple reason that they are not an insurance company, rather a medical and hospital service corporation.

House Bill 2203 would resolve the inconsistency that remains in our insurance laws and we would encourage your support of the legislation. With that Madam Chair, the Department would be happy to respond to any questions the committee may have. Craig VanAalst from the Accident & Health Division of the Insurance Department is here if the committee has technical questions about this bill.

Jarrod Forbes
Assistant Director
Government Affairs

Attachment 1
3/17/05
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Statement of Brad Smoot
Legislative Counsel
Blue Cross Blue Shield of Kansas City
Senate Financial Institutions and Insurance
Regarding 2005 House Bill 2203
March 17, 2005

Madam Chair and Members:

Blue Cross Blue Shield of Kansas City is a nonprofit medical and hospital service corporation serving the greater Kansas City area, including Johnson and Wyandotte Counties in Kansas. We provide insurance coverage to approximately 300,000 of your fellow Kansans. We are pleased to support 2005 House Bill 2203.

Federal and state laws require insurers to offer continued coverage to persons who have lost coverage for a variety of reasons (lost job and group coverage; employer drops coverage; etc.). Federal law recognizes an exception to that requirement when a person is dropped from coverage for "cause," such as fraud. Kansas law has long allowed HMO's to refuse continuation benefits when fraud is involved. Last year, the Legislature extended the right to refuse continuation benefits to other types of health policies. Unfortunately, we failed to amend the special laws governing BCBSKC, the only non profit medical and hospital service corporation doing business in Kansas. Those sections of Kansas law are amended by HB 2203 in the same manner as last year's bill, HB 2597.

We view this amendment as purely technical, allowing BCBSKC to operate in the same fashion as all other health insurance plans with regard to continuation of coverage when fraud is involved. We urge your support of 2005 HB 2203. Thank you.

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GACHES, BRADEN, BARBEE & ASSOCIATES
PUBLIC AFFAIRS & ASSOCIATION MANAGEMENT
825 S. Kansas Avenue, Suite 500 • Topeka, Kansas 66612 • Phone: (785) 233-4512 • Fax: (785) 233-2206

Senate Financial Institutions and Insurance Committee
Testimony of First Data Corporation/Western Union
In Support of Substitute for HB 2276 Re: Transmission of Money
Provided by Ron Gaches
Thursday, March 17, 2005

Thank you Senate Teichman and members of the committee for the opportunity to appear on behalf of First Data Corporation in support of HB 2276. The bill is intended to clarify the application of our credit card surcharge statute to transmission of money services.

The bill provides that "Any person complying with the provisions of KSA 9-508 through 9-513, and amendments thereto, may charge a different price for a transmission of money service based on the mode of transmission used in the transaction, so long as the price charged for the services is the same for all forms of payment which are accepted within the same mode of transmission."

The Substitute Bill was prepared in the House Financial Institutions Committee with input from the Bank Commissioner's Office and the Revisor's Office. There was no opposition to achieving the intent of the bill, and, after reaching a consensus among every one about how to draft the language, there was no opposition to the bill.

The attached explainer prepared by Western Union discusses the need for the bill in more detail. Thank you for your consideration and we urge your support of HB 2276.

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WESTERN UNION LEGISLATIVE SUMMARY

Purpose

This proposed language would merely clarify that the credit card surcharge statute was not meant to apply to the different methods consumers use to send money (e.g. walk-up locations, telephone, Internet) through a licensed money transmitter, so long as the price is consistent within each of these methods of delivery. For example, the price charged for conducting a money transfer transaction over the telephone could be different than the price charged at walk-up locations, so long as credit card and debit card users pay the same price when using the telephone service.

Reason for Legislative Remedy

Telephone and Internet transactions are more expensive for several reasons: (i) the expense incurred to verify the consumer's identity; (ii) the expense incurred to authenticate the consumer's credit or debit card, and verify the availability of funds; and (iii) the additional exposure to fraud due to the anonymity associated with transactions that take place over the telephone and the Internet.

Consequently, telephone and Internet money transfer transactions are subject to additional steps and procedures that make them more costly and riskier to provide than walk-up transactions. At walk-up locations, cash is the method of payment that is accepted.

Background

As a licensed, nation-wide money transmitter, Western Union's money transfer services are available to consumers at over 200,000 locations in over 195 countries and territories. Consumers who send money to one another through Western Union can do it three different ways: (1) using walk-up locations; (2) using the telephone; and (3) using the Internet.

- Consumers using the walk-up service must pay with cash. Credit and debit cards are typically not accepted at walk-up locations.
- The telephone service requires consumers to pay for the transaction with their credit or debit card. This service is not available at the walk-up locations. Customers using this service dial a toll-free number that initially connects them to an Interactive Voice Response (IVR) system. First, the customer is given security information that warns them about consumer fraud schemes. Next, the customer is asked to enter the amount of money they wish to send, and are then told how much the transaction will cost. Next, the customer is prompted to enter their bankcard (debit or credit card) information, their date of birth, and their billing telephone number. At this point in time, the customer is connected to a customer service representative who engages with customer. The operator then asks the caller to provide the name of the person who will pick up the money, the expected location (e.g. city and state) where the money will be picked up, the name and address of the sender, etc. Western Union then authenticates the consumer's bankcard, verifies the availability of funds, and validates the identify of the card user. If this information is verified, Western Union will then complete the transaction (while the consumer remains on the line), and send

a receipt to the consumer, either by e-mail or regular mail (depending on the customer's preference).

- The Internet service also requires consumers to pay with their credit or debit card. This service is not available at walk-up locations.

States with Similar Statutes

11 states in the nation, including Kansas, have credit card surcharge statutes. Of those 11, we have successfully clarified the law (with language similar to what we propose here in Kansas) in Texas, Colorado, and Florida. Consequently, we are working to clarify the surcharge statute in the remaining eight (8) states. These eight states include California (Internet only), Connecticut, Kansas, Oklahoma, Maine, Massachusetts, Minnesota, and New York.

Polsinelli | Shalton
Welte | Suelthaus PC

Memorandum

TO: THE HONORABLE RUTH TEICHMAN, CHAIR
SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

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

RE: HOUSE BILL 2357

DATE: MARCH 14, 2005

Madame Chair, Members of the Committee: My name is Bill Sneed and I represent State Farm Insurance Companies ("State Farm"). State Farm is the largest insurer of homes and autos in the United States and Kansas. We appreciate the opportunity to testify on House Bill 2357. This bill creates a self evaluative privilege for insurers.

Our laws should protect those who play by the rules. Yet, in today's increasingly hostile legal environment, playing by the rules in not as simple as it should be. Insurance companies interested in using proactive self-evaluative audits are limited by the reality that these audits may be used against them by insurance regulators, or in court – even if problems identified in the audits have been corrected.

House Bill 2357 addresses these concerns by creating a self-evaluative privilege to protect these audits. Currently five states, New Jersey, North Dakota, Oregon, Illinois, and Michigan as well as the District of Columbia, have a self evaluative audit privilege for insurers. These statutes share several key features with House Bill 2357. For the privilege to apply;

- There must be an insurance compliance audit. An audit is a voluntary internal evaluation not otherwise required by law that is designed to identify and prevent noncompliance and improve compliance with federal or state laws and regulations.
- Audits may not be used to hide illegal or improper activity.
- Insurance compliance audit material may to subject to disclosure to a regulator or law enforcement official.

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- The privilege does not apply to preexisting materials. Documents qualifying for the privilege are those prepared in connection with - - but not prior to - - - the audit. It does not protect documents created in the normal course of business, and access to insurance company records will remain the same as it is today.

- The privilege does not create immunity from lawsuits or from prosecution. It does not prevent the use of other evidence, beyond the insurance compliance audit, to establish liability. It is only designed to protect the voluntary audit from being used against the company.

Given the limited application of the privilege why is it desirable? One of the features of the privilege is that it encourages self correction. A regulatory environment that encourages voluntary self-correction is in the public's best interest. Unfortunately, it is unlikely without the privilege, as insurers can not afford the risk. The New Jersey Legislature noted if audits are ". . . available to third parties . . . and potentially can result in the insurance carrier's liability to such third parties, the insurance carrier may be discouraged from making those additional efforts . . ."

The self evaluative privilege also enhances regulatory enforcement. Because of limited resources regulators may be unable to address the breadth of conduct identified and corrected by these audits. Self correction allows insurers to inform a regulator of corrected conduct without fear of repercussion form the regulator, or in the courts, and is free to the taxpayer. Consequently, allowing regulators to use their limited resources more effectively.

Finally the privilege encourages a cost effective and efficient resolution of compliance issues. Everyone recognizes that litigation can be a deterrent to undesirable behavior, but it is a lengthy and expensive process, which only addresses the specific wrongs alleged by the plaintiff. Self correction can deliver more immediate and comprehensive results at a lower cost. In today's litigious environment, everyone is familiar with the image of an attorney telling a jury to send a message to punish the defendant. Absent the privilege, that company's self evaluative audit may serve as the basis for that charge – even when the company has corrected the problem before the lawsuit was filed. This is a deterrent to responsible corporate behavior.

State Farm supports House Bill 2357. At a time when business ethics and corporate compliance are under extensive scrutiny, this privilege encourages complete, candid analysis, the implementation of preventive measures and, if needed, remediation. State Farm Appreciates the opportunity to speak to the Committee on this issue, and we respectfully urge the Committee to pass the bill.

Respectfully submitted,

William W. Sneed

BRAD SMOOT
ATTORNEY AT LAW

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STATEMENT OF BRAD SMOOT
LEGISLATIVE COUNSEL
AMERICAN INSURANCE ASSOCIATION
SENATE FINANCIAL INSTITUTIONS AND INSURANCE
REGARDING HB 2357
MARCH 17, 2005

Madam Chair and Members:

On behalf of the American Insurance Association (AIA), I am pleased to appear in support of HB 2357, creating a statutory privilege for the conduct of internal self-evaluative audits by insurers. AIA is a trade association of 430 insurers providing business and personal insurance to customers in all fifty states. Our product lines include business, general liability, workers compensation, malpractice, auto and homeowners. We urge your favorable consideration of HB 2357.

The bill before you is based on a model bill prepared by the National Conference of Insurance Legislators (NCOIL). Although evidentiary rules in civil and criminal actions can be complicated, the concept here is not. It is good public policy – good for consumers, government and private businesses – for businesses, including insurance companies, to evaluate themselves from time to time to improve their manner of operating, uncover unlawful or improper conduct and make the changes necessary to correct the mistakes or wrongdoing that may be found. Our laws should encourage such behavior.

Numerous Kansas laws shield various types of information from being admitted in administrative, civil and criminal proceedings in order to protect the judicial process or promote quality in professional or business practices. For example, we all are aware of the attorney /client privilege (K.S.A. 60-426). Peer review proceedings are another good example (K.S.A. 60-4915). And, although there are countless other examples, the one which seems most similar is K.S.A. 60-3332, et seq., as amended. These provisions authorize a business to conduct a "voluntary, internal assessment, evaluation or review" of a facility to determine if the facility and its operations are in compliance with environmental laws. For an interesting article on this subject, see "Compliance Through Cooperation," Robert W. Parnoacott, 65 J.K.B.A. No. 5, 22 (1996).

While insurance departments, lawsuits and criminal investigations serve a valuable purpose in keeping insurers in line, they are not necessarily the only or best method for obtaining industry compliance with Kansas insurance laws. An internal audit can correct flaws in a process or practice that otherwise might go unnoticed for years and cause significant cost and inconvenience to customers, regulators and the insurer itself.

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Although the bill covers a lot of detail, it is most important to note that the privilege does not exclude evidence (records or information) at hearing or trial that are uncovered during an internal audit. Rather, the privilege only protects the audit document itself and the person or persons doing the audit. And, even then, there are exceptions where, for example, the audit is being used to commit fraud or the insurer has not taken steps to remedy the problems disclosed by the audit. In such cases, the privilege would not apply.

An insurance self audit privilege would encourage insurers to "clean house" regularly without fear of reprisal for their trouble. Seems to us that our entire industry would be healthier, more compliant and consumer friendly if we were encouraged to routinely "take stock" in our operations. HB 2357 encourages such behavior. Thank you.

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TESTIMONY ON HB 2357
March 17, 2005

TO: **Senate Financial Institutions and Insurance Committee**

RE: House Bill No. 2357

Madam Chair and Members of the Committee:

Thank you for this opportunity to appear before the Committee. I am David Hanson and am appearing on behalf of the Kansas Association of Property and Casualty Insurance Companies and the Kansas Life and Health Insurance Association, whose members are domestic insurance companies in Kansas, and also on behalf of PCI, the Property Casualty Insurers Association of America, with over 1,000 members in the U.S. writing about 38% of the property-casualty market, last year.

In the latter part of 1997, representatives of several of our member companies were invited to join with legislative leaders, former Insurance Commissioner Sebelius and business development leaders in a task force to explore ways to improve the business climate for insurance in Kansas. The task force recognized the positive impact that insurers have on the economy and sent a clear message to insurers that Kansas wants insurers to bring the jobs and other benefits that only an increased competitive environment in insurance, like any industry, can bring.

Consequently, we try to alert you to positive enhancements, as well as to unduly burdensome or unnecessary restrictions. We realize that this often entails a tough policy decision on your part. Insurers are also faced with difficult decisions in managing their businesses. The provisions contained in this bill go to the very heart of the decisions insurers need to be able to make without undue interference in order to be competitive. And, to be competitive in insurance means to be able to offer the best coverages at the best rates to consumers.

Our domestic companies have remained in Kansas through the years, including the last twenty years when Kansas was sometimes near the top in the most severe catastrophic storm losses nationwide. Our companies have continued to provide insurance coverage while some other companies withdrew from the State. We support the provisions of House Bill 2357 as allowing out companies to be able to conduct compliance self audits in order to detect and correct deficiencies and protecting the confidentiality of that audit. Our companies need to be allowed to reasonably manage their businesses, including management of compliance issues. Without the protections afforded by this bill, out companies would be penalized and, in effect, discouraged from conducting self audits. We believe the protections afforded in the bill are balanced to not only protect the interests of our companies and their policyholders, but also include provisions for the Insurance Commissioner and other government officials to challenge any claim of privilege and for courts to examine the documents in question and determine if they are in fact privileged. This concept is not novel or unique, but instead consistent with our general constitutional privilege against self-incrimination. Similar provisions were enacted in Kansas in 1995 for businesses to conduct environmental compliance self audits and protect the results as privileged and confidential. Though enacted in 1995, it does not appear that there have been very many, if any, reported court cases reflecting challenges to or problems with those provision, nor have any amendments been adopted.

The bill before you would establish a similar system for our member companies for their compliance self-audits and we would urge your support of the bill.

Respectfully,

David A. Hanson

DAVID A. HANSON

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MARCH 17, 2005

KANSAS SENATE

FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

HOUSE BILL 2357

TESTIMONY
By
THE AMERICAN COUNCIL OF LIFE INSURERS

The American Council of Life Insurers (ACLI) represents three hundred and fifty-four (354) member companies operating within the United States. These 354 member companies account for 74 percent of total assets, 69 percent of the life insurance premiums, 79 percent of annuity considerations, 51 percent of disability income insurance premiums and 81 percent of long-term care insurance premiums in the United States.

Thank you for the opportunity to comment in support of House Bill 2357.

Insurance companies are subject to a staggering array of state and federal laws and regulations.

Member companies of the ACLI sell life insurance, annuities, disability income insurance and long-term care insurance. As such, these companies are subject to myriad federal laws, such as Gramm-Leach-Bliley, HIPAA, ERISA and the Patriot Act. In addition, both the companies and their products are subject to federal tax laws and regulations as well as federal securities laws and regulations.

However, since the insurance industry remains primarily state regulated, that means that insurance companies are also subject to fifty sets of state insurance laws and regulations. As you know, these laws and regulations deal with a company's licensure, its financial condition, the design and marketing of its products, the payment of state taxes, fees and assessments and the agents selling the company's products.

This vast system of laws and regulations would be challenging enough if the system remained static. But, in fact, the laws and regulations change annually. Because of this, many companies doing business nationally (and in some cases, internationally, as well) have set up entire departments whose sole purpose is to keep track of all of the laws and regulations that the company is subject to.

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In order to maintain compliance with all of these laws and regulations, companies need to be able to conduct internal examinations and audits to be sure that the applicable requirements and prohibitions are being followed. Accordingly, it is good public policy to encourage companies to conduct these internal audits.

Not surprisingly, however, in today's litigious society, many companies are concerned about conducting these important internal compliance audits because of the fear that the audit documents will be used against the company in some future lawsuit.

Accordingly, in order to encourage internal compliance audits and thereby promote the early detection and correction of any compliance problems, these internal audits need the confidentiality protection provided by House Bill 2357.

The National Conference of Insurance Legislators (NCOIL) recognized this need for confidential protection when they created and adopted the Model law upon which HB 2357 is based.

ACLI supports enactment of HB 2357 because:

1. It is good public policy to encourage insurance companies to conduct internal self-evaluations in order to identify and correct instances of non-compliance with laws and regulations.
2. The insurance department's normal regulatory review and examinations will be made more efficient and effective when insurers have already undertaken internal self-evaluations.
3. Without the privilege protection provided by HB 2357, insurance companies will be less inclined to conduct internal self-audits for fear of the litigation risk.
4. Consumers will benefit from greater scrutiny of a company's compliance with laws and regulation that were designed to protect consumers.
5. Insurers will benefit from HB 2357's protection against unwarranted discovery of documentation which could encourage increased litigation.
6. Regulators will benefit by still being able to have access to needed documents from the insurance companies and regulators will thereby be able to focus their resources on monitoring the practices of companies in need of compliance supervision.

Thank you for the opportunity to comment in support of HB 2357.

Jim Hall
Senior Counsel and Director,
Central States Region
The American Council of Life Insurers

FarmersAlliance

Insuring Rural America Since 1888

Self-Audit Privilege

Senate FI&I Committee

H.B. 2357

Madam Chairman and Members of the Committee, I appreciate this opportunity to share our views in support of H.B. 2357.

My name is Rick Wilborn. I am Vice President of Government Affairs for the Farmers Alliance Insurance Companies. Farmers Alliance is a domestic property and casualty company that has been operating in and committed to Kansas since 1888. We also write property and casualty insurance in eight other contiguous states.

In the early 1990's, Illinois took the lead and completely deregulated rate, rule and form filings. Now, many states have followed suit in varying degrees. Kansas and the contiguous states to Kansas have adopted some sort of rate, rule and form deregulation.

In turn, this left the business of regulation by Insurance Departments to focus on financial oversight and market conduct activity. With the increased interest in market conduct examinations by insurance departments, carriers like Farmers Alliance Mutual Insurance Company, initiated some sort of a self-audit to be certain of following regs, statutes, and rules as it relates to the insurance practices serving the policyholder.

Insurance departments became aware of the trend of companies initiating self-audit practices and conducting internal market conduct type examinations. They begin requesting access to working papers, audit reports and other road maps in finding violations to pose penalties on companies after the companies had taken the initiative to audit their compliance and correct any problems they found.

Most insurers feel that disclosure of privilege and confidential documents to the Insurance Department may waive the attorney-client and other privileges, and subject these documents to disclosures to trial attorneys and others under rules of civil procedure and evidence. Disclosure to the Insurance Departments of compliance documents may also make the documents available to the public under the freedom of information laws. A few insurance regulators have also denied the applicability of the attorney-client privilege and refused to acknowledge it.

In 1997, Illinois enacted the first insurance self-audit compliance privilege law in an attempt to resolve growing problems between the insurance companies and the insurance department examiners. Under the Illinois approach, specifically defined self-audit compliance documents are privilege, need not be disclosed to the Insurance Department, and cannot be admitted as evidence in any criminal, civil or administrative proceedings.

More and more insurance carriers and trade associations are approaching insurance commissioners to include a self-audit privilege legislation with a request for the commissioners to include it in the Insurance Department's legislative package. Most industry's initial position

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Farmers Alliance Mutual Insurance Company • Farmers Crop Insurance Alliance, Inc.
Alliance Administrators, Inc. • Alliance Indemnity Company • Alliance Insurance Company, Inc.

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has been that the company self-audit documents are privileged and confidential and need not be disclosed to regulators except if the insurer chooses to do so voluntarily. If the insurers know their internal documents are not subject to disclosure, they will be encouraged to actively review their compliance with state laws and regulations so that protection of confidential and privileged information promotes effective state insurance regulation. Regulators generally do favor immunity for insurers to disclose self-audit documents.

The industry, in general, along with NCOIL, has urged the National Association of Insurance Commissioners to develop some sort of a model bill addressing the self-audit privilege issue.

A minority continues to believe that the regulators should have complete access to an insured's books and records, privileges not withstanding. Others believe that insurers shall disclose all books and records to the Insurance Departments, provided that regulators take steps to prevent them from redisclosure to third parties.

We at the Farmers Alliance Companies conduct audits on various lines of business, our agents licensing practices, complaint registers and a host of other areas that we spot check from time to time. It has been our practice to report the findings to our Board of Directors' Audit Committee by means of a summary. There is no question in my mind that our self-audit practices have aided our Operations Division and other support divisions to do a better job of following regulatory guidelines. This, of course, provides improved quality and service to our policyholders.

We strongly support the passage of H.B. 2357.

Richard E. Wilborn, CPCU
Vice President, Government Affairs

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Kansas Association of Health Plans

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Fax 785-233-3518
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TO: The Senate Financial Institutions and Insurance Committee

FROM: Larrie Ann Lower
Executive Director

DATE: March 17, 2005

RE: HB 2357; Self Audit Privilege for Insurance Companies

Madame Chair and members of the Committee. Thank you for allowing the Kansas Association of Health Plans (KAHP) to submit written testimony today.

The KAHP is a nonprofit association dedicated to providing information on managed care health plans. Members of the KAHP are Kansas licensed health maintenance organizations, preferred provider organizations and other entities that are connected to managed care. KAHP members serve most all of the Kansans enrolled in a Kansas licensed HMO. KAHP members also serve the Kansans enrolled in HealthWave and medicaid managed care and also many of the Kansans enrolled in PPO's and self insured plans. We appreciate the opportunity to provide comment on HB 2357.

The KAHP supports HB 2357. We believe this bill encourages insurance companies to evaluate themselves and make corrections and changes that may be needed in order to potentially make the company a better corporate citizen.

Through various statutes the state has encouraged similar actions in other industries. Peer review proceedings for the medical community and internal assessments for the environmental industry are examples.

We encourage the committee to favorably consider this legislation. Thank you and I'll be happy to answer any questions you may have.

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Kansas Action Network

The Coalition for Workers' Rights, Social Justice and Economic Fairness

Community Action Network
Flint Hills Living Wage Coalition
GI Forum
Grow Kansas
International Association of Machinists and Aerospace Workers District 70 and Locals 2799, 733, 774, 834
Kansas AFL-CIO
Kansas Ecumenical Ministries
Kansas Farmers Union
Lawrence Coalition for Peace and Justice
Manhattan Alliance for Peace and Justice
Peace and Social Justice Center of South Central Kansas
Plumbers and Pipefitters Local 441
Salina Central Labor Union
Sisters of St. Joseph of Concordia
Southeast Kansas Independent Living Resource Center
Statewide Independent Living Council of Kansas
Topeka Center for Peace and Justice
Topeka Independent Living Resource Center
Topeka Federation of Labor
Topeka LULAC
Tri-County Labor Council of Eastern Kansas
United Methodist Church–East Kansas Conference
United Steelworkers of America Local 3092
Wichita/Hutchison Labor Federation

March 17, 2005

RE: Testimony in opposition to HB 2357

Members of the Financial Institutions and Insurance Committee,

Thank you for the opportunity to address this committee in opposition to House Bill 2357. My name is Jeff Kniep and I am the President of the Kansas Action Network. K.A.N. is a coalition of more than thirty organizations from all across Kansas speaking out on behalf of workers rights, social justice, and economic fairness.

As I was reviewing information for this testimony I read about more fraudulent occurrences at insurance companies that I cared to. Some of them being the same insurance companies I use. I also read testimony given in the past in support of this legislation. Keeping fraudulent behavior secret is not a deterrent. Secrets beget secrets. Consumers lose their jobs or their insurance coverage on a daily basis because of fraudulent claims and behaviors. Those fraudulent behaviors are not kept secret. Companies use that information to deter fraud. This in the name of keeping premium costs to a minimum. In many cases consumers are spending large portions of their monthly salaries on insurance coverage. That is an investment and it should be treated as such. Would you want to invest a large portion of your salary in a company that was secretly, and legally, committing fraud?

Business ethics and corporate compliance are under extensive scrutiny for very good reasons. Fraud is fraud, and it should be dealt with accordingly. Giving a company the legal right to keep secrets about fraud is counter-productive to improving ethical behavior and compliance to existing laws. Thank you, again, for the opportunity for K.A.N. to voice opposition to H.B. 2357.

Respectfully Submitted,

Jeff Kniep
President
Kansas Action Network

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• fax 785-232-4145 • KSAction@aol.com • www.KSActionNet.org •

KANSAS TRIAL LAWYERS ASSOCIATION

Lawyers Representing Consumers

To: Chairperson Ruth Teichman and the Senate Committee on Financial Institutions and Insurance

From: Terry Humphrey for the Kansas Trial Lawyers Association

Date: March 17, 2005

Re: HB 2357

Madam Chairman and Members of the Committee, I am here today on behalf of the Kansas Trial Lawyers Association. KTLA is a statewide, nonprofit organization of lawyers who represent consumers and advocate for the safety of families and the preservation of the civil justice system. I appreciate the opportunity to present testimony in opposition to HB 2357.

KTLA became aware of HB 2357 after it had been heard by the House Insurance Committee and was nearly rejected by the House Committee of the Whole. The bill raises serious concerns because it creates an absolute privilege for self-evaluative audits performed by insurers on their own business activities and their compliance with state and federal laws. As a result of the privilege granted by HB 2357, self-evaluative audits and documents related to the audits would be undiscoverable and inadmissible in a court of law or in administrative proceedings, and are not subject to production under the Open Records Act. Such information is important to the public, the courts, and regulators and permitting it to be held in secrecy undermines consumer protection.

KTLA interprets the broad definition in HB 2357 of "insurance compliance self-evaluative audit document'' to mean that almost anything related to the business of insurance or the operations of an insurer could become privileged. Under such a broad definition, an insurer could hide information about practices including but not limited to broker kickbacks, price fixing, premium collection, physician reimbursements, and decisions regarding payment of health care claims.

We have been asked whether the absolute privilege granted to insurers in HB 2357 is granted to any other industry in Kansas. Our review is that it is not. There are only two privileges in current law that we are aware of that are self-evaluative, but they are not comparable to the privilege granted in HB 2357. At K.S.A. 60-3332 et.seq., a *limited* privilege is granted for "voluntary, internal assessment, evaluation or review" of a facility to determine its compliance with state environmental laws. However, the granting of the privilege is limited: the audits must be completed within a reasonable time and cannot be uninterrupted or continuous. In addition, the party asserting the privilege must have a

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Terry Humphrey, Executive Director

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compliance plan in place and must have taken corrective action as a result of the audit or the privilege does not apply. There are no similar obligations of insurers with regard to the absolute privilege granted them in HB 2357.

Second, the absolute privilege in HB 2357 goes well beyond the privilege afforded to doctors and hospitals for peer review and risk management. In the recent case of *Adams v. St. Francis*, 264 Kan. 144 (1998), the major theme of the Court's opinion is that a trial is a search for truth, and that factual accounts of events, witnesses statements and similar evidence are not protected by any privilege and cannot be suppressed on that basis. The Court also noted that an injured person has a "fundamental right" to have access to all relevant facts in a case, and that only the "mental impressions and conclusions of persons actually performing the peer review or risk management functions" are subject to the peer review or risk management privilege.

HB 2357 is being advanced as a means to encourage insurers to conduct audits for purposes of an internal review of the company's compliance with state and federal laws. While KTLA supports insurers in their efforts to attain crisp compliance with state and federal laws, we believe that self-evaluative audits should already be the business practice of every insurer. Compliance with Kansas insurance laws is mandatory, not discretionary. From a regulatory standpoint, allowing insurers to conceal their business practices from the public would seem to diminish compliance with state laws, not enhance it.

KTLA believes that the proponents have not demonstrated the compelling circumstances that require the absolute privilege granted in HB 2357. Moreover, it has not been shown that there is a problem with insurance compliance in Kansas that would be fixed by enacting an absolute privilege.

Kansas consumers are dependent on the Legislature, regulators, and the courts to protect them from insurer misbehavior and bad conduct. HB 2357 would severely limit these entities from acting on consumers' behalf. The conduct of insurers and their management is an important public policy issue: just this week, the chief executive of the world's largest insurer, AIG, stepped down after it became clear that he had personally initiated a complex transaction that regulators believe improperly boosted AIG's earnings (see attached article). Last October, New York State Attorney General Eliot Spitzer sued Marsh & McLennan for defrauding its customers by bid-rigging and steering business to insurers in exchange for special commissions (see attached article). In Kansas, 25 medical groups representing 250 doctors have filed four class-action lawsuits against health insurers alleging collusion to depress physician reimbursements (see attached article). In the post-Enron world where scrutiny of internal corporate activities is on the increase, the secrecy and shadow permitted by HB 2357 is the wrong direction for Kansas. We respectfully request that HB 2357 not be advanced.

www.usatoday.com
USA TODAY
Money
SECTION B
Tuesday, March 15, 2005

AIG's chief expected to resign

Insurance industry scandal embroils powerful family

By Thor Valdmanis
USA TODAY

NEW YORK — Maurice Greenberg is expected to step down this morning as CEO of American International Group — which would make him the second member of the Greenberg insurance family triumvirate to fall amid an industrywide fraud scandal.

The AIG board demanded Greenberg's resignation over the weekend after it became clear the 79-year-old World War II veteran had personally initiated a complex transaction four years ago that regulators believe improperly boosted AIG's earnings, according to two people briefed on the issue.

Greenberg, who during four decades built AIG into the world's largest insurer, with a market value of almost $170 billion, agreed in heated negotiations Monday to relinquish the CEO title and stay on as nonexecutive chairman. Martin Sullivan, AIG's co-chief operating officer and vice chairman, takes over as CEO — only the third since AIG began as a small insurance office in the Chinese city of Shanghai in 1919.

Many Wall Street analysts said AIG would survive the sudden management shake-up, arguing the group has a first-rate management team and strong property-casualty and other insurance businesses. AIG shares fell 86 cents to $63.85 Monday on investor skittishness ahead of the actual announcement.

By Diane Bondareff, Bloomberg News

Empire builder: Over four decades Maurice Greenberg built AIG into the world's largest insurer.

A combative and shrewd businessman, Greenberg fought hard to keep his job, according to people familiar with the matter.

But the AIG board, led by former Nasdaq chief Frank Zarb, said Greenberg had become a lightning rod after criticizing regulators for an "overexuberance" in the crackdown on corporate wrongdoing. Greenberg was told his resignation was essential if AIG was going to settle damaging ongoing federal and state probes.

AIG did not return calls seeking comment.

Greenberg becomes the third high-profile departure in recent weeks after the boards of Hewlett-Packard and Boeing recently forced out CEOs.

But Greenberg, one of the company's largest shareholders, with a net worth of over $3.2 billion, was widely regarded as untouchable. He's the patriarch of an insurance industry dynasty that once included sons Jeffrey, as CEO of broker Marsh & McLennan, and Evan, current CEO of Bermuda-based insurer ACE.

That reputation began to unravel last October when New York Attorney General Eliot Spitzer sued Marsh for defrauding its customers by bid-rigging and steering business to insurers in exchange for special commissions. Favored insurers included AIG and ACE.

Jeffrey Greenberg was soon forced to resign, and Marsh recently paid $850 million to settle charges.

AIG is now under pressure. Two former executives pleaded guilty to criminal charges stemming from Spitzer's probes. The biggest worry is AIG's use of "finite insurance," or financial reinsurance, which critics say is used to artificially boost earnings.

The elder Greenberg lost his job for helping put together a transaction between AIG and Warren Buffett's General Reinsurance unit four years ago that apparently was intended to shore up AIG's reserves, people with knowledge of the situation say.

KansasCity.com

Posted on Sat, Feb. 26, 2005

Physicians sue health insurers

By JULIUS A. KARASH
The Kansas City Star

Alleging a conspiracy to suppress payments to physicians, more than 25 medical groups representing about 250 doctors have filed four class-action lawsuits against area health insurers.

The suits were filed in Jackson County Circuit Court and Wyandotte County District Court. Two were filed Feb. 14 and two were filed Feb. 17 — the day before President Bush signed legislation that requires most class-action lawsuits to be filed in federal court.

The plaintiffs include New Century Health Quality Alliance Inc., a Mission-based independent practice association comprising 123 primary-care doctors.

"Historically, at least over the past five years, we have data that we as physicians are compensated at up to 30 and sometimes 40 percent less than physicians in the same specialty, providing the same services, in areas such as Wichita, Des Moines, and Springfield (Mo.)," physician Beth Gallup, president of New Century Health, said Friday. "It appears that they're (insurance companies) colluding to depress the compensation that physicians receive."

Gallup said the plaintiffs expect that most area physicians will support the lawsuits.

The defendants include Blue Cross and Blue Shield of Kansas City, Coventry Health Care of Kansas Inc., UnitedHealthcare, Humana Health Plan Inc., Cigna HealthCare and Aetna.

"We categorically deny any collusion with other insurance companies to suppress physician reimbursement," said Blue Cross spokeswoman Susan Johnson. "To the contrary, we have been a leader in working with physicians to address these issues."

In addition, Johnson said, "we suspect the number and timing of these lawsuits may be related to President Bush's recent bill which curtails class-action lawsuits."

Gloria Barone, a spokeswoman for Cigna in Philadelphia, said her company considered the lawsuits without merit.

Mary Sellers, a spokeswoman for Humana in Louisville, Ky., said Humana "believes the allegations are nothing new and that the language is actually taken from some existing lawsuits in other states, particularly a class-action suit in Miami, Florida."

The other health insurers declined to comment or could not be reached for comment.

The lawsuits allege that the health insurers violated antitrust laws by fixing prices and engaging in other monopolistic behavior, such as refusing to negotiate reasonable reimbursements.

The suits also allege that the health insurers refused to pay agreed-upon rates.

Two of the suits state that "as a direct result of the defendants' anti-competitive actions, the health-care community in the region has suffered and is teetering on the brink of a health-care crisis," with problems such as doctors leaving the area and new physicians refusing to move here.

All four suits seek a jury trial. The suits do not specify the amount of damages they are seeking, but do request damages and attorney fees that could amount to tens of millions of dollars.

Given the complex nature of the litigation and the number of parties involved, it could take a year or two before trial

ces are scheduled.

To reach Julius A. Karash, call

(816) 234-4918 or send e-mail to *jkarash@kcstar.com*.

First glance

• Defendants in the lawsuits include Blue Cross and Blue Shield of Kansas City, Coventry Health Care of Kansas Inc., UnitedHealthcare, Humana Health Plan Inc., Cigna HealthCare and Aetna.

To: Chairperson Ruth Teichman and the Senate Committee on Financial Institutions and Insurance

From: Jacob S. Graybill
Patterson, Gott & Graybill, LC

Date: March 17, 2005

Re: HB 2357

Madam Chairman and Members of the Committee, I am a practicing attorney and a member of the Kansas Trial Lawyers Association. I appreciate the opportunity to present testimony in opposition to HB 2357.

Based on the experience of my practice, I believe that HB 2357 will tend to facilitate insurer misconduct of the type described and documented in the document I distributed at the hearing, "Documented Instances of Insurers' Bad Behavior". The bill as drafted fails to adequately describe and limit the scope of what the bill loosely refers to as an "insurance compliance audit".

Elsewhere in current law there are provisions related to privileges for self-evaluative audits. However, these provisions are clearly distinguishable from the audits described in HB 2357. For example, K.S.A. 60-3332 defines "Audit' and "Audit report" as follows:

(a) "Audit" means a voluntary, internal assessment, evaluation or review, not otherwise required by environmental law, that is performed by the owner or operator, the owner's or operator's employees, or a qualified auditor and initiated by the owner or operator of a facility for the express and specific purpose of determining whether a facility, operation within a facility or facility management system complies with environmental laws. Once initiated an audit shall be completed within a reasonable period of time. Nothing in this section shall be construed to authorize uninterrupted or continuous auditing.
(b) "Audit report" means a set of documents, each labeled "Audit Report: Privileged Document" and prepared as a result of an audit. An audit report may include the following supporting information, if collected or developed for the primary purpose and in the course of an audit: Field notes and records of observations, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, computer-generated or electronically recorded information, maps, charts, graphs and surveys. An audit report, when completed, may have three components:
(1) An audit report prepared by the auditor, which may include the scope of the audit, the information gained in the audit, conclusions and recommendations, together with exhibits and appendices;
(2) memoranda and documents analyzing all or part of the audit report and discussing potential implementation issues; and

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(3) an implementation plan that addresses correcting past noncompliance, improving current compliance and preventing future noncompliance.

Additionally, HB 2357 as drafted goes far beyond audits related to compliance with insurance statutes and administrative regulations, and encompasses loose and undefined "industry or professional standards". The bill does not define the term. Unlike K.S.A. 60-3334, HB 2357 as drafted allows insurers to use HB 2357 as a shield to prevent disclosure of past noncompliance.

In closing, I note that HB 2357 encourages insurers to mislead regulators by voluntarily producing cherry-picked documents without producing all of the relevant material. Such activity would not be permitted in relationship to other privileges such as the attorney-client privilege or work-product privilege.

I respectfully request that the Committee not pass HB 2357.

Jacob Graybeal

Documented instances of Insurers bad behavior

State Farm Insurance Company - Alleged collusion with medical review companies to deny needed medical

Two "Dateline NBC" shows, aired on June 23rd and July 25th, exposed questionable review practices of two medical review companies, used by State Farm Insurance Company. The show illustrated disturbing practices of how State Farm handled auto accident claims and provided evidence that State Farm colludes with the medical review companies to deny needed coverage to auto accident victims[1].

After the show was broadcast, Senate Commerce Committee Chairman John McCain wrote National Association of Insurance Commissioners (NAIC) President George Nichols (KY) asking him "to review these allegations and report back" to the committee. In response to Senator McCain's request, Commissioner Nichols has decided to launch a multi-state market conduct examination. The examination will focus on how State Farm utilizes the paper review process.

Met-Life - Churning - $1.7 billion

Metropolitan Life Insurance Company, the nation's second largest life insurance company, agreed to pay $1.7 billion to settle allegations that 7 million of its current and former policyholders were hit with deceptive sales practices[2].

Prudential - Churning, and destruction of evidence - $2 billion

In 1996 Prudential Insurance Company of America agreed to pay a $35 million fine and set aside money to settle policyholders lawsuits after an investigation found the company had defrauded more than 10 million life insurance customers[3]. By 1999 Prudential estimated those settlements would total more than $2 billion.[1]

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[1]For transcripts see website: http://www.msnbc.com/news/437401.asp

[2]"*Met Life to Pay $1.7 Billion to Settle Lawsuits on Policy Sales*", Liz Pulliam, Los Angeles Times, August, 1999

[3]"*Prudential to Pay Policyholders $410 Million for Its Sales Tactics*", Joseph Treaster, New York Times, September, 1996

[1]"*Met Life*" supra

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Prudential's 1996 internal audit conducted after the fine was paid found that the company was still only "partially on target" in supervising its sales force, leaving policyholders open to "unauthorized" activity and improper practices. Yet another internal memo said that the company was not able to always detect fraud committed by its employees against policyholders, and concluded that the company had underestimated the incidence of such fraud[2].

In 1997 a federal judge fined Prudential $1 million after finding that the company had deliberately destroyed or hidden documents in connection with the very same fraud suit[3].

Columbia/HCA - Medicare Fraud - $745 million

In May 2000 Columbia/HCA Healthcare Corp. agreed to pay $745 million to settle civil charges that it systematically defrauded government health insurance programs. In the wake of the case the U.S. government launched a nationwide investigation into corporate Medicare fraud that it claimed totaled more than $30 billion a year[4].

Blue Cross, Connecticut - Medicare Fraud - $74 million

In December 1999, Anthem Blue Cross and Blue Shield of Connecticut agreed to pay the federal government $49.1 million as part of a $74 million civil settlement to resolve claims of Medicare fraud.[5]

Empire Blue Cross - admitted misleading state legislators

In 1993 health insurance company Empire Blue Cross and Blue Shield admitted misleading state regulators with false financial data to help secure a rescue plan for their company[6].

Interstate - embezzlement - $30 million

The former owner of North Carolina's seventh largest insurance company and his vice president - a former state insurance regulator - were convicted of a total of 150 counts of mail and bank fraud, money laundering and conspiracy after embezzling more than $30 million in 1990. The company, Interstate Casualty Insurance Company, collapsed leaving 200 people without jobs and 90,000 people without auto insurance.[1]

United Independent / Financial Security - Embezzlement - $17 million

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[2] "*Prudential Sales Problems Persisted in 1996*", Leslie Scism, Wall Street Journal, December, 1997

[3] "*Judge Fines Prudential $1 Million*", Associated Press, The New Orleans Times-Picayune, January, 1997

[4] "*2 Hospital Execs Found Guilty in Medicare Case*", Reuters, Los Angeles Times, July, 1999

[5] "U.S. Settles Case Against Anthem For $74 Million", Laurie McGinley, Wall Street Journal, December, 1999

[6] "*Erroneous Report by Health Insurer Aided Legal Fight*", Jane Fritsch, New York Times, 6/18/1993

[1] "*2 Insterstate Casualty Officials Convicted on Fraud Charges*", Debbie Norton, Journal of Commerce, December, 1991

In 1992 the principal executive of what had been Hawaii's two largest auto insurers was convicted of fraud after he systematically bilked the company for as much as $17 million, and deliberately refused to pay claims in order to keep the premium monies[2].

Guarantee Security - Embezzlement and fraud - $300 million

In August 1991 Guarantee Security Life Insurance Company collapsed under the weight of $300 million in debt and was seized by Florida regulators, stranding 57,000 policyholders in 40 states. State insurance regulators said the company had been brought down by rampant fraud and the excesses of its chairman, Mark Sandford, who had looted the company to pay for a lavish lifestyle and dubious investments, including a $17 million loan to a nude bar chain[3].

ITT Hartford, Aetna, Allstate, Cigna et al - antitrust violations - $36 million

In 1994 32 insurers agreed to a $36 million settlement to answer charges that the industry conspired to manipulate the insurance market, causing severe limitations in the availability and affordability of insurance. Nineteen attorneys general had alleged that a wave of closings of parks, playgrounds and other municipal facilities was due to the companies' collusion[4].

State Farm - Generic parts fraud - $1.19 billion

In 1999, an Illinois judge ruled that State Farm had defrauded policyholders by requiring that damages from automobile accidents be repaired with lower-priced generic parts, and ordered the insurer to pay $730 million in actual and punitive damages. A jury in the same court decided that State Farm had breached its contracts with policyholders by having repair shops use parts that were not authorized by auto manufacturers, and ordered the insurance company to pay $456.1 million, bringing the total damages from the case to $1.19 billion[5].

State Farm - Fraud

Former State Farm employee Amy Zuniga revealed that State Farm's officials routinely defrauded policyholders and lied in court. She said in sworn statements that in the aftermath of the 1994 Northridge earthquake State Farm agents attempted to avoid paying claims by systematically forging signatures to make it appear that policy holders had declined earthquake coverage[6].

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[2] "*Hawaiian Executive Gets Prison for Fraud*", Jerry Goldberg, Journal of Commerce, January, 1992

[3] "*Castle in the Sand*", Martha Brannigan, Wall Street Journal, December, 1991

[4] "*Insurers Settle Antitrust Suit Over Collusion*", Leslie Scism, Wall Street Journal, October, 1994

[5] "*Judge Assesses State Farm $730 Million in Fraud Case*", Keith Bradsher, New York Times, October, 1999

[6] "*State Farm Returns Documents to Court File*", Solomon Moore, Los Angeles Times, June, 1997

LEGISLATURE OF KANSAS

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Testimony for the Senate Financial Institutions and Insurance Committee on HB 2357

Barb Hinton, Legislative Post Auditor
March 17, 2005

Madame Chairman and members of the Committee, thank you for allowing me to appear before you regarding HB 2357. As written, we think this bill could be interpreted to preclude our access to confidential records in the possession of the Insurance Commissioner as part of an audit authorized by the Legislative Post Audit Committee.

Our access to confidential agency records is mandated in the Legislative Post Audit Act. K.S.A. 46-1106(g) says that:

> In the discharge of the duties imposed under the legislative post audit act, the post auditor...shall have access to all books, accounts, records, files, documents and correspondence, *confidential or otherwise*, of any person or state agency subject to the legislative post audit act or in the custody of any such person or state agency."

Such access is critical to preserving our ability to effectively carry out the legislative audit function. If the Legislative Post Audit Committee approved an audit looking into the Insurance Department's oversight of the insurance industry, part of our normal audit work would involve a review of information provided to the Department [from whatever sources] about insurance companies' activities, and an assessment of whether the Department had taken appropriate oversight action in response to that information.

Given the provisions in HB 2357 that say any compliance self-evaluative audit document in the insurance commissioner's possession remains the property of the insurance company, along with other provisions, we are concerned the law could be interpreted to preclude our access to this information during the course of an approved audit—regardless of the access provisions of the Post Audit Act. [Confidential records we review during an audit do <u>not</u> become public or lose their confidential status. The Legislative Post Audit Act specifically prohibits us from **<u>releasing or reporting</u>** the contents of confidential documents **<u>in any identifiable manner</u>**, and imposes the same penalties on us for any breach of confidentiality as on the agency.]

The Committee may wish to clarify within the bill whether Post Audit would have access to such records during the course of an approved audit.

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77-514 and amendments thereto.

Sec. 7. The insurance compliance self-evaluative privilege created by this act shall apply to all litigation or administrative proceedings pending on the effective date of this act.

Sec. 8. No provision of this act nor the release of any self-evaluative audit document hereunder shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

Sec. 9. This act shall take effect and be in force from and after its publication in the statute book.

Sec. 9. (a) No provision of this act shall be construed to prohibit the post auditor in the discharge of the duties imposed under the legislative post audit act for the purposes of any audit or audit work conducted in accordance with the provisions of the legislative post audit act, K.S.A. 46-1101 et seq., and amendments thereto, from having access to any insurance compliance self-evaluative audit document or any other document or information of an insurance company related thereto in the possession of the insurance commissioner

(b) In accordance with the provisions of the legislative post audit act, the post auditor shall be subject to the same duty of confidentiality imposed by this act on the commissioner, and shall be subject to any civil or criminal penalties imposed by law for violations of such duty of confidentiality

(c) For the purposes of this subsection "post auditor" means the post auditor specified in K.S.A. 46-1102 and amendments thereto. Post auditor shall also include any employee of the division of post audit established pursuant to K.S.A. 46-1103, and amendments thereto.

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