Approved: February 11, 1993
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on February 10, 1993 in Room 527-S of the Capitol.

All members were present except: Representative Kenneth King, Excused

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee:
Bill Sneed, American Investors and HIAA
Terry Tiede, Insurance Department
Joe Furjanic, Kansas Chiropractors Association
Dave Charay, Kansas Employees Health
Chip Wheelen, Kansas Medical Society
Bill Pitzenberger, Blue Cross/Blue Shield
William Warfle, Credit Union Department

Hearing on HB 2177: Insurance holding companies

Bill Sneed, American Investors, requested tthat the Committee make technical changes to legislation which will be enacted July 1, 1993. This legislation is part of an attempt to make Kansas one of the first state insurance departments to be certified by the National Association of Insurance Commissioners. It deals with the regulation of dividends of an insurance company, and dividends declared by an insurance company to a parent or another affiliated company within a holding company organization (Attachment 1).

Terry Tiede, Assistant Insurance Commissioner, stated that the Insurance Department had no objections to the language as it stands now nor with the suggested amendment.

Hearing on HB 2171 - Prohibiting discrimination in health and accident insurance policies between certain health care providers

Joe Furjanic, Kansas Chiropractic Association, stated that this bill would prohibit broad exclusions such as denial of coverage given by health care providers included in the insurance equality laws. When discriminatory activity takes place against a Chiropractor, this bill would give the Insurance Commissioner the authority to enforce equality statutes through rules and regs as violations of the unfair trade practice act (Attachment 2). A booklet, Chiropractic: A Primary Care Gatekeeper, also was given to Committee members. Customers are often unaware of what they purchase regarding latitude in physician choice in health insurance. Full disclosure of limitations of policies should be required by agents selling health insurance policies. Medical doctors rarely make referrals to chiropractors even if the patient requests such as referral.

David Hanzlick, Kansas Dental Association, presented written testimony in support of the bill (Attachment 3).

Bill Sneed, representing Health Insurance Association of America, spoke in opposition to the bill because the mandates found in Chapter 40 must be abided by in all insurance policies (Attachment 4). If the mandates are included in the policy, the Insurance Department would refuse to approve the filing. If an insurance company utilizes a policy form that has not been approved for filing, there are various administrative procedures the Department can take. The bill may be an attempt to utilize the mandate laws to avoid managed care types of procedures, whether deductibles, utilization review, etc.

Dave Charay, Health Benefits Administrator, stated that the bill would eliminate the option of insurance companies to offer limited networks such as Preferred Provider Organizations (PPOs), Health Maintenance Organizations HMO's), etc (Attachment 5). Provider networks are one of the few effective ways to control the rising costs of health care services and health insurance benefits offered to active and retired state

employees. Some state plans do allow self-referral and some plans carry deductibles and the customer can use chiropractors without being referred. No chiropractors are listed as primary care physicians in Kansas.

Chip Wheelen, Kansas Medical Society, stated that the reason chiropractors cannot be listed as primary care physicians is because they are not licensed to practice medicine or surgery in Kansas.

Bill Pitzenberger, Blue Cross/Blue Shield, share with the Committee copies of the statute in which it is illegal to write laws prohibiting chiropractors from practicing or being paid (Attachment 6). Managed care programs afford the public lower costs and these costs would rise if they include self-referral. Blue Cross/Blue Shield does require that a physician have admitting privileges to a hospital and be licensed to use drug and medical therapies.

Wayne Warfle, Credit Union Department, requested legislation regarding the expulsion of members, treatment of confidential information, and the addition of technical information to existing statutes (Attachment 7). Representative Cornfield moved that the bill be introduced into legislation. Representative Helgerson seconded the motion. The motion carried.

Representative Kline moved that HB 2138 be passed out favorably and placed on the Consent Calendar. The motion was seconded by Representative Cox. Motion carried.

Representative Cox moved that the minutes of February 9 be approved. Representative Correll seconded the motion. The motion carried.

The meeting adjourned at 4:50 p.m. The next meeting is scheduled for February 11, 1993.

# GUEST LIST

COMMITTEE: Financial Institutions & Insurance DATE: 2-10-93

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATIO |
|---|---|---|
| WAYNE WARFEL | TOPEKA | KS ST DEPT CREDIT UNIONS |
| Gail Kasson | Lawrence | " " " " |
| [illegible] | TOPEKA | KOHE |
| [illegible] | " | KS [illegible] |
| Lee Wright | Overland Park | Farmers Ins. Group |
| Rick Liby | Topeka | Gehrt & Roberts |
| Jerel Wright | Topeka | KS Credit Union Assn |
| Bill Pitzenberger | Topeka | Blue Cross/Blue Shield |
| Bill Sneed | TOPEKA | Am Ins Life |
| Bill Sneed | TOPEKA | KIIA |
| HAROLD RIEKE | TOPEKA | KAOM |
| Dick Brock | " | Ins Dept |
| Terry Tiede | " | Ins Dept. |
| DAVE CHARAY | " | Health Care Comm. |
| Jim Neuhoff | Topeka | KS AFL-CIO |
| Chip Wheelen | Topeka | KS Medical Soc. |
| LARRY MAGILL | " | PIIAK |
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# MEMORANDUM

TO: The Honorable William Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed
Legislative Counsel
AmVestors Financial Corporation

DATE: February 10, 1993

RE: House Bill No. 2177

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Mr. Chairman, Members of the Committee: My name is William W. Sneed and I am here today testifying on behalf of my client, American Investors Life Insurance Company, and its parent corporation, AmVestors Financial Corporation. American Investors Life Insurance Company is a Kansas-domiciled stock life insurance company whose headquarters are located here in Topeka, Kansas. We appreciate the opportunity to testify in favor of H.B. 2177. This bill deals with a highly technical area of the Kansas Insurance Code; however, we believe that the amendments proposed in the bill in no way will drastically affect the regulation of insurance companies and their ultimate parent holding company.

For reference, initially let me go through the changes found in the bill. Inasmuch as the amendments are rather small and the statutes are very long, it is my hope this will be helpful to your review of the bill.

1. K.S.A. 40-233 is amended by adding a redrafted definition of how an insurance company can pay a "regular" dividend. That new language is found on page one, lines 39-43. This definition replaces the definition that has been struck on lines 21-28.

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The stricken language found on lines 29-39 is at the request of the Kansas Insurance Department inasmuch as it is their belief that the language is obsolete and not necessary.

2. The first amendment to K.S.A. 40-3305 is found on page three, lines 29-31. This amendment changes the notification to the Kansas Insurance Department of payments to shareholders from fifteen business days to five business days following the declaration, and also informing the Department of its payment no less than ten business days prior to the actual payment.

3. The next change to K.S.A. 40-3305 is found on page six, line 26. This is changing the language of "lesser" to "greater." Further, on line 34 we have deleted the term "profits" and inserted the word "earned" prior to "surplus" to correspond with the new definition found at page one, to which I made earlier reference.

4. Finally, the last proposed amendment to K.S.A. 40-3305 is found on page eight, lines 4-5, and adds an addition criteria that the Department will utilize in reviewing extraordinary dividends.

A discussion on the history of why this bill is in front of you is probably necessary so that it is more understandable as to why we contend these changes are not dramatic and are appropriate. As this Committee is aware, the National Association of Insurance Commissioners ("NAIC"), in an attempt to solidify state regulation, instituted a program where states would become "certified" by the NAIC if they met certain rigid requirements. These requirements generally entailed proof that various uniform laws were in place which the NAIC deemed to be most important in the regulation of insurance

companies, primarily dealing with financial areas. In an attempt to become one of the first state insurance departments to be certified (which Kansas successfully accomplished), the Department over the last two years has presented to the Kansas legislature various model bills promulgated by the NAIC to help promote additional regulatory tools for the Kansas Insurance Department. One of those issues deals with the regulation of dividends of an insurance company, and more particularly, dividends declared by an insurance company to a parent or another affiliated company within a holding company organization.

Generally, you have two types of dividends. First is what could commonly be referred to as a "regular" dividend. Payment of these dividends is governed by K.S.A. 40-233. In an oversimplification, these dividends can only be paid out of monies found in earned surplus. Earned surplus is a mathematical formula derived when the company prepares its annual statement.

Additionally, insurance companies are allowed to pay dividends beyond that amount which is found in earned surplus, and such dividends are classified as "extraordinary" dividends. The payment of these dividends is provided under K.S.A. 40-3305.

The NAIC initially took the position that the amount of money to be allowed to be paid as an extraordinary dividend should be determined as the "lesser" of a mathematical formula as opposed to the "greater" of this mathematical formula.

When the Kansas Insurance Department brought this proposal to the Kansas legislature last year, the insurance industry, along with other Insurance Departments, were

still working with the NAIC on this particular provision. What the industry and other Insurance Departments were proposing was that such a severe limitation on extraordinary dividends might not be appropriate, particularly if a given state had additional state laws and procedures dealing with the declaration and payment of these types of dividends. Unfortunately, a finalization of these discussions was not going to be available by the end of the 1992 legislative session. Thus, the Insurance Department presented the amendment to K.S.A. 40-3305, but with an effective date of July 1, 1993. Therefore, the change from "greater" to "lesser" has not yet come into effect. Thereafter, during 1992 the NAIC did rule that other language in lieu of the change from "greater" to "lesser" would be appropriate if a given state had certain regulatory laws and/or procedures.

Inasmuch as the Kansas Insurance Department has consistently held higher standards for the payment of dividends, the only changes needed are very minor. Thus, this supports our position that the changes we are proposing do not have that adverse an effect on the oversight of the Kansas Insurance Department of insurance companies in the payment of their dividends.

If the "lesser than" language was retained in the statute and was allowed to go into effect on July 1, 1993, Kansas would have an overburdensome limitation on these dividends and Kansas companies would be placed at a disadvantage to companies in other states. We believe that such an overburdensome law will have an adverse effect on the Kansas domestic insurance industry and could in many instances also prohibit this industry from continuing to grow by virtue of utilizing the marketplace for additional capital.



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Consequently, inasmuch as the Kansas Insurance Department has already had high standards in regard to this issue, coupled with the additional requirements that I have denoted in the amendments in H.B. 2177, we contend that the need for implementation of the "lesser than" language as opposed to maintaining the "greater than" language is necessary. Accordingly, we would appreciate the Committee's favorable treatment of this bill and respectfully request that it be passed out favorably.

I appreciate the opportunity to testify, and if you have any questions or comments, please feel free to contact me.

Respectfully submitted,

William W. Sneed



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Kansas Chiropractic Association

Before the House Financial Institutions
and Insurance Committee
February 10, 1993

Testimony of Joe Furjanic
Executive Director, Kansas Chiropractic Association
In Support of HB 2171

Thank you Mr. Chairman and members of the Committee for the opportunity to speak in support of HB 2171.

HB 2171 is necessary legislation to protect a number of health care providers from the current trend of the insurance industry which denies coverage for services rendered by certain professionals. This bill is intended to cover all insurance companies licensed to do business in the state of Kansas along with managed care systems such as HMOs and PPOs. HB 2171 would prohibit broad exclusions such as denial of coverage given by health care providers included in the insurance equality laws.

Legislation is also necessary to prohibit narrowly worded exclusions which are intended to limit access to certain health care providers.

An example of an insurance equality law is K.S.A. 40-2101 which states:

> No policies, contracts or agreements for medical service shall deny reimbursement or indemnification for any service within scope of practice licensed under Kansas healing arts act. Notwithstanding any provision of any individual, group or blanket policy of accident and sickness, medical or surgical expense insurance coverage or any provision of a policy, contract, plan or

Financial Institutions & Insurance
Attachment 2
February 10, 1993

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> agreement for medical service, issued on or after the effective date of this act, whenever such policy, contract, plan or agreement provides for reimbursement or indemnity for any service which is within the lawful scope of practice of any practitioner licensed under the Kansas healing arts act, reimbursement or indemnification under such policy contract, plan or agreement shall not be denied when such service is rendered by any such licensed practitioner within the lawful scope of this license.

At face value, this law states that Doctors of Chiropractic are to be treated the same as MDs and DOs regarding reimbursement. However, when a discriminatory activity takes place against a Chiropractor there is no mechanism in place to enforce the law. HB 2171 would rectify this situation by giving the Insurance Commissioner the authority to enforce these equality statutes through rules and regs as violations of the unfair trade practice act.

I have enclosed a Texas Attorney General opinion interpreting the Texas Insurance Equality Law and a directive from the Texas State Board of Insurance to all insurance companies licensed in Texas. Also enclosed are some examples of what was held to be discriminatory practice under Texas' Insurance Equality Law.

Finally, I have enclosed a booklet published by the Foundation for Chiropractic Education and Research entitled <u>Chiropractic: A Primary Care Gatekeeper</u> as background material as to how KCA feels Chiropractic fits into the overall health care system.

# The Attorney General of Texas

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March 19, 1985

Mr. Lyndon L. Olson, Jr.
Chairman
State Board of Insurance
1110 San Jacinto Boulevard
Austin, Texas 78786

Opinion No. JM-301

Re: Whether the Texas Insurance Code prohibits health insurance policy provisions that discriminate with regard to payment for treatment by certain types of health care practitioners based on (1) an express exclusion of such practitioners or (2) "place and manner" restrictions that indirectly exclude such practitioners

Dear Mr. Olson:

You have asked our opinion regarding whether the State Board of Insurance should approve the following types of sickness and accident insurance policy provisions:

> 1. Payment of benefits . . . is specifically limited to instances where treatment is provided by a doctor of medicine. No benefits will be paid for treatment by a doctor of dentistry, doctor of chiropractic, doctor of optometry, doctor of podiatry, doctor in psychology, audiologist, or speech-language pathologist.
>
> 2. Benefits are payable for manipulation of the spine. However, benefits will be paid only when such treatment is provided in a hospital.
>
> 3. Benefits are payable for manipulation of the spine when treatment is provided while the insured is under general anesthesia.
>
> 4. Benefits are payable for treatment of mental illness or psychological impairment, except that benefits payable when the insured is an outpatient and treatment is provided by a psychologist are limited to $20 per treatment and 25 treatments per year. There is no limit on benefits payable when treatment is provided by a

> psychiatrist other than co-insurance and deductibles.
>
> 5. Benefits are payable for treatment of chiropractic services, except that benefits are payable on an out-patient basis or schedule when treatment is provided by a chiropractor and are limited to $20 per treatment and 20 treatments per year. There is no limit on benefits payable, except co-insurance and deductibles, when treatment is provided by a doctor of medicine.

The requirement that insurance policy forms be approved by the State Board of Insurance as well as the grounds on which the board shall disapprove forms are set forth in article 3.42 of the Insurance Code. Article 3.42(a) provides:

> No policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization insurance, medical or surgical insurance, [or] group medical or surgical insurance . . . shall be delivered, issued or used in this state . . . unless the form of said policy, contract or certificate has been filed with the State Board of Insurance and approved by said Board. . . .

Article 3.42(g) provides:

> The State Board of Insurance shall forthwith disapprove any . . . form, or withdraw any previous approval thereto if, and only if,
>
> (1) It is in any respect in violation of or does not comply with this Code.
>
> (2) It contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive or contrary to law or to the public policy of this state.
>
> (3) It has any title, heading or other indication of its provisions which is misleading. (Emphasis added).

You specifically ask:

> 1. Does the insured's article 21.52, Insurance Code, freedom to select a practitioner negate

provisions such as (1) above which exclude specified practitioners?

2. Are restrictions of the type set out in (2) through (5) above allowable when no provision enumerates which practitioners will be recognized and which will not be? In other words, when not excluded by reference, can a practitioner be excluded by restrictions on the place and manner in which treatment be administered?

The provision of the Insurance Code about which you inquire, article 21.52, section 3, states:

> Any person who is issued . . . any health insurance policy . . . by any insurance company, association, or organization . . . may select a licensed doctor of podiatric medicine, a licensed dentist, or a doctor of chiropractic to perform the medical or surgical services or procedures scheduled in the policy which fall within the scope of the license of that practitioner, a licensed doctor of optometry to perform the services or procedures scheduled in the policy which fall within the scope of the license of that doctor of optometry, an audiologist to measure hearing . . . or a speech-language pathologist to evaluate speech and language . . . if those services or procedures are scheduled in the policy. The payment or reimbursement by the insurance company . . . shall not be denied because the same were performed by a licensed doctor of podiatric medicine, a licensed doctor of optometry, a licensed doctor of chiropractic, a licensed dentist, an audiologist, or a speech-language pathologist. There shall not be any classification, differentation, or other discrimination in the payment schedule or the payment provisions . . . nor in the amount. . . .

The present list of practitioners in article 21.52 is the result of several amendments to the original article enacted in 1977. In legislative committee hearings, the bills which added practitioners to article 21.52 were frequently referred to as "freedom of choice" bills. The purpose was to permit the insured, not the insurer, to select the kind of practitioner that would perform the services covered in the insurance policy. See, e.g., Testimony on Senate Bill No. 96, Senate Economic Development Committee, 66th Leg., public hearing, recorded Jan. 29, 1979, available in Legislative Reference Library; Id., House Committee on Health Services, recorded Feb. 21, 1979; Testimony on House Bill No. 860, Senate Committeee on Human

Resources, 66th Leg., public hearing, recorded Apr. 25, 1979, available in Legislative Reference Library.

We conclude that article 21.52 expressly prohibits an insurer from discriminating against an insured, with regard to payment or reimbursement, based on the type of practitioner the insured selects to provide medical care. The prohibition against discrimination extends to the services of six kinds of health care practitioners: podiatrists, dentists, chiropractors, optometrists, audiologists and speech-language pathologists. The prohibition against discrimination applies with respect to those services (1) covered by the relevant insurance policy and (2) within the scope of the affected practitioner's license or certification. Policy provisions which exclude, restrict or limit payment or reimbursement for such services when they are provided by any of the specified practitioners, and do not provide the same exclusion, restriction or limitation on those services when they are provided by a doctor of medicine, are unlawful.

We believe the first and fifth policy provisions about which you inquire must be disapproved because they expressly discriminate against one or more of the practitioners identified in article 21.52.

Article 21.35A of the Texas Insurance Code is similar to article 21.52 and relevant to the fourth policy provision about which you inquire. Article 21.35A prohibits discrimination against a person who elects to obtain treatment from a licensed psychologist rather than a doctor of medicine, in a group insurance policy or group hospital plan, as follows:

> Any person who is covered by a policy . . . of group insurance or of a group hospital plan . . . and whose policy . . . provides for services or partial or total reimbursement for services that are within the scope of practice of a licensed psychologist, is entitled to obtain these services or receive reimbursement for these services regardless of whether the services are performed by a licensed doctor of medicine or a licensed psychologist.

The fourth policy provision about which you inquire expressly differentiates between the amount of reimbursement available for services of a psychologist and the amount of reimbursement available for services of a psychiatrist. Special limitations apply to reimbursement for psychologists that do not apply to psychiatrists. Thus, we believe the fourth policy provision you identify must also be disapproved when it appears in a policy or plan subject to article 21.35A.

We also conclude that the plain language of articles 21.52 and 21.35A prohibits not only those forms which expressly state that the amount or existence of reimbursement shall vary according to the type

of practitioner providing the service, as in the first, fourth and fifth policy provisions you quote, but also those forms which have the same or similar discriminatory effect, such as the second and third policy provisions quoted.

To determine whether the policy discriminates against certain types of practitioners, the "place or manner" restrictions about which you inquire must be evaluated in light of the nature of the benefits to which they apply. The second and third provisions state that benefits are payable for manipulation of the spine. However, the second provision limits the benefits to manipulation performed in a hospital and the third provision limits the benefits to manipulation performed while the insured is under general anesthesia.

Manipulation of the spine is a service commonly provided by chiropractors and is within the scope of their licenses. Chiropractors' licenses do not, however, permit them to administer general anesthesia or admit patients to hospitals. Thus, the effect of the quoted restrictions is a categorical exclusion of the only type of practitioner commonly associated with the treatment purportedly within the scope of the insurance policy coverage. Since chiropractors are among the practitioners identified in article 21.52, such provisions subvert the statute and are nonenforceable.

Our conclusion is based on the plain language of the statute and legislative intent.

The plain language of articles 21.52 and 21.35A does not limit the prohibition against discrimination to any particular method or means of discrimination. On the contrary, article 21.52, for example, expressly states that there shall not be "any classification, differentiation, or other discrimination . . . in the amount or manner of payment or reimbursement. . . ."

To give effect to legislative intent, a statute should be given a "practical and reasonable construction rather than a literal or thwarting construction." See Denver-Albuquerque Motor Transport, Inc. v. State, 584 S.W.2d 738, 740 (Tex. Civ. App. - Amarillo 1979, no writ) and cases cited therein. Articles 21.52 and 21.35A prohibit discrimination or differentiation based upon the type of practitioner providing the service if the practitioner is among those specified. To accomplish the object of the legislation, such discrimination must be prohibited not only when it is the result of expressly discriminatory restrictions but also when it results from discriminatory restrictions disguised as non-discriminatory restrictions limitations on the place or manner in which the service is provided.

Neither article 21.35A nor article 21.52 appears intended to alter the basic nature of the benefits provided in an insurance policy except to the extent necessary to prohibit discrimination based on categorical distinctions between certain types of practitioners. The Texas Supreme Court has held that the State Board of Insurance may

consider factors other than those which appear within the "four corners of the policy" in deciding whether to approve a policy form. Key Western Life Insurance Co. v. State Board of Insurance, 350 S.W.2d 839, 850-52 (Tex. 1961). Therefore, the State Board of Insurance may consider factors deemed necessary to determine the discriminatory purpose or effect of any given policy provision.

You have also directed our attention to article 3.70-2(B) of the Insurance Code, which provides:

> No policy of accident and sickness insurance shall make benefits contingent upon treatment or examination by a particular practitioner or by particular practitioners of the healing arts hereinafter designated unless such policy contains a provision designating the practitioner or practitioners who will be recognized by the insurer and those who will not be recognized by the insurer. . . . In designating the practitioners who will and will not be recognized, such provision shall use the following terms: Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Chiropractic, Doctor of Optometry, Doctor of Podiatry, Audiologist, and Speech-language Pathologist.

Another version of this amended article passed by the legislature in a separate bill at the same session as the above-quoted version includes psychologists and excludes audiologists and speech-language pathologists from the list of practitioners.

Neither version of article 3.70-2(B) should be read to conflict with article 21.52. Article 3.70-2(B) neither authorizes nor prohibits any discrimination between practitioners. Article 3.70-2(B) merely prescribes the format for excluding practitioners when such exclusions are not prohibited elsewhere in the Insurance Code.

Even if article 3.70-2(B) and article 21.52 were ambiguous or potentially contradictory, however, various rules of statutory construction support the foregoing interpretation. Statutes should be construed in harmony with other statutes unless a contrary intention is clearly manifest. Freels v. Walker, 26 S.W.2d 627, 630 (Tex. 1930). Even when the literal language of one enactment conflicts with that of another, they should be read together and harmonized, if reasonably possible. Dallas Railway & Terminal Co. v. Strickland Transportation Co., 225 S.W.2d 901, 905 (Tex. Civ. App. - Amarillo 1949, no writ). This proposition is especially true with respect to statutes which, as here, deal with the same general subject, and are therefore considered to be in pari materia. See Texas State Board of Pharmacy v. Kittman, 550 S.W.2d 104, 106 (Tex. Civ. App. - Tyler 1977, no writ); 2A C. Sands, Sutherland Statutory Construction, §51.02, at 453-54 (rev. 4th ed. 1984).

Our construction of article 3.70-2(B) is also supported by the rule that, by reason of the disparity in bargaining positions between insurance companies and purchasers of insurance, statutes regulating the relationships of insurers and insureds are interpreted strictly against the insurance companies and liberally in favor of insured persons. 2A C. Sands, supra, §58.04, at 716; 3 id., §70.05, at 308 (4th ed. 1974). This rule favors upholding the policy embodied in article 21.52 of giving the insured freedom to choose among various kinds of practitioners.

We find no indication of legislative intent which justifies a contrary interpretation. Both article 21.52 and article 3.70-2(B) were amended in 1983. Article 21.52, section 3 was amended to add audiologists and speech-language pathologists (without the express "scope of license" requirement included for the other specified practitioners). Acts 1983, 68th Leg., ch. 380, at 2065. As part of the same bill, article 3.70-2(B) was also amended to add "audiologists" and "speech language pathologists." A second bill, which also amended article 3.70-2(B), was passed later during the same session. This second bill added "Doctor of Psychology" to 3.70-2(B) but did not include "audiologists" or "speech language pathologists." Senate Bill No. 255, 68th Leg., ch. 492, at 2887. Both bills were signed by the governor.

The amendment of both article 21.52, section 3 and article 3.70-2(B) in the same session reinforces the reasons for construing the statutes to give meaning and effect to both. See Myers v. Crenshaw, 137 S.W.2d 7, 13 (Tex. 1940) (two statutes relating to same subject and amended at same session should be read together); 2A C. Sands, supra, §51.03, at 467. The principle that statutes in pari materia should be construed together is a restatement of the presumption against the implied repeal of statutes. See Fortinberry v. State ex rel. Myers, 283 S.W. 146, 149 (Tex. 1926); 2A C. Sands, supra, §51.01, at 449. The additions to the list of practitioners made in both articles during the same legislative session plainly indicates that the legislature did not contemplate any conflict or intend an implied repeal of either article.

## S U M M A R Y

Article 21.52, section 3, of the Texas Insurance Code prohibits discrimination by an insurer against an insured with regard to payment of benefits based on the insured's election to obtain the services of a podiatrist, dentist, chiropractor, optometrist, audiologist or speech-language pathologist rather than a doctor of medicine or some other kind of health care practitioner. The prohibition applies if the services obtained are within the scope of services covered

by the policy and within the scope of the practitioner's license or certification. The prohibition extends to those insurance policy provisions which expressly discriminate against one or more of the specified types of practitioners, as well as to those provisions, including place and manner restrictions, which have the same or a similar discriminatory purpose or effect.

Very truly yours

Jim Mattox

JIM MATTOX
Attorney General of Texas

TOM GREEN
First Assistant Attorney General

DAVID R. RICHARDS
Executive Assistant Attorney General

RICK GILPIN
Chairman, Opinion Committee

Prepared by Marianne Woodard
Assistant Attorney General

APPROVED:
OPINION COMMITTEE

Colin Carl
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# STATE BOARD OF INSURANCE

1110 SAN JACINTO AUSTIN, TEXAS 78701-1998

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DOYCE R. LEE, Commissioner
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NICHOLAS MURPHY, Chief Clerk

June 8, 1988

TO: ALL COMPANIES LICENSED TO WRITE ACCIDENT AND HEALTH COVERAGE IN TEXAS

It has come to the attention of the State Board of Insurance, that some insurers doing business in Texas are not interpreting Art. 21.52 of the Texas Insurance Code Annotated in a manner consistent with Attorney General's Opinion No. JM-301 as it relates to chiropractic services. Art. 21.52 §3 provides in pertinent part:

> "any person, who is issued... any health insurance policy... by any insurance company, association or organization may select a licensed doctor of podiatric medicine, a licensed dentist, a doctor of chiropractic, a licensed doctor of optometry, an audiologist, a speech-language pathologist, a certified social worker or a licensed dietitian to perform the medical or surgical services or procedure scheduled in the policy which fall within the scope of the license of that practitioner... The payment or reimbursement shall not be denied because the same were performed by a licensed doctor of podiatric medicine, a licensed dentist, a doctor of chiropractic, a licensed doctor of optometry, an audiologist, a speech-language pathologist, a certified social worker or a licensed dietitian... There shall not be any classification, differentiation, or other discrimination in the payment schedule or the payment provisions... nor in the amount..."

Except for coverages mandated by statute, a policy provision providing a limitation for the number of visits that will be paid for a particular condition, regardless of the type of physician/provider who treats the condition, is permissible. However to apply restrictions on one type of physician/provider, based upon the number of treatment visits by an insured, without applying the same restrictions to all physicians/providers is improper.

Additionally, it is improper to limit payment to the providers as enumerated in Art. 21.52 of the Texas Insurance Code Annotated, at a different percentage level than paid for the same or similar treatment by other classes of physicians. A medical expense benefit is diagnosis for, or treatment of certain conditions that are covered and should not be based on who does the diagnosis or treatment of the covered condition.



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Benefit limitations or exclusions shall not be designed to unfairly discriminate against the usual and customary treatment procedures of any class of providers as are enumerated in Art. 21.52 of the Texas Insurance Code Annotated.

In summary, Attorney General's Opinion No. JM-301 interprets this provision to mean that if a health insurance policy or plan provides payment of a medical expense benefit, which providers as enumerated in Art. 21.52 of the Texas Insurance Code Annotated, can offer, then reimbursement for treatment by such providers must be paid without unfair discimination.

It is the position of the State Board of Insurance that all insurers shall comply with Art. 21.52 of the Texas Insurance Code Annotated. Attached is a copy of Attorney General's Opinion No. JM-301.

A. W. Pogue
Deputy Insurance Commissioner



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Payment of benefits...is specifically limited to instances where treatment is provided by a doctor of medicine. No benefits will be paid for treatment by a doctor of chiropractic.

Benefits are payable for manipulation of the spine. However, benefits will be paid only when such treatment is provided in a hospital.

Benefits are payable for manipulation of the spine only when treatment is provided while the insured is under general anesthesia, or during a cutting operation.

Benefits are payable for manipulation of the spine, except that benefits for treatment by a chiropractor are limited to $20.00 per treatment, one treatment per day and 20 treatments per year, while there is no limit on benefits when treatment is provided by a doctor of medicine.

Benefits are payable for manipulation of the spine, except that benefits for treatment by a chiropractor are limited to $500.00 per year, while there is no limit on benefits when treatment is provided by a doctor of medicine.

Benefits are payable for treatment of the spine, except that benefits for treatment by a chiropractor are paid at 50%, while benefits for treatment by a medical doctor are paid at 80% of usual, reasonable and customary charges.

Benefits are payable for treatment of the spine, except that benefits for treatment by a chiropractor such as physical therapy, diathermy, massage or spinal manipulation for dislocation, subluxations, or misplacement of vertebrae, or strains and sprains of soft tissue related to the spine are limited to $10.00 per treatment or service, while there is no limit on benefits when treatment is provided by a doctor of medicine or by a physical therapist.

Benefits are payable for treatment of the spine, except that benefits for treatment by a chiropractor are excluded if treatment involves manual manipulation (with or without the application of treatment modalities such as, but not limited to, diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions which are in excess of $10.00 per visit, one visit per day, and 50 visits per calendar year.

Benefits are payable for treatment of the spine, except that benefits for treatment by a chiropractor are excluded for manipulation of the spine and other parts of the body to eliminate nerve interference or its effect. This includes any manual or mechanical means to detect or correct body imbalance, distortion, or subluxation related to the spine.

KDA
KANSAS DENTAL ASSOCIATION

Statement by David Hanzlick
House Committee on Insurance
House Bill 2171
February 10, 1993

Mr. Chairman and members of the Committee, my name is David Hanzlick. I am the Assistant Director of the Kansas Dental Association. I appreciate the opportunity to express the KDA's support of the concept of House Bill 2171.

The purpose of the legislation is to strengthen the effectiveness of the "Insurance Equality" statutes. The Insurance Equality statutes ensures that a patient with a broken jaw has the right to seek treatment from either a dentist or a physician, and receive reimbursement from a third party payor. Without that protection, the patient might lose the right to seek care from his or her selected provider.

House Bill 2171 would enforce the Insurance Equality statutes through the application of the Unfair Trade Practices Act. Current law contains no enforcement mechanism.

Mr. Chairman, it is important to note that the Insurance Equality statutes do not mandate payment for particular procedures by third party payors. They do, however, help assure access to care by increasing the number of health care providers who are available to treat patients with third party coverage.

Again, thank you for the opportunity to appear in support of House Bill 2171.

5200 Huntoon
Topeka, Kansas 66604-2365
913-272-7360

Financial Institutions + Insurance
Attachment 3
Feb. 10, 1993

# MEMORANDUM

TO: The Honorable William Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: William W. Sneed
Legislative Counsel
Health Insurance Association of America

DATE: February 10, 1993

RE: House Bill 2171

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Mr. Chairman, Members of the Committee: My name is Bill Sneed and I am Legislative Counsel for the Health Insurance Association of America ("HIAA"). The HIAA is a health insurance trade association consisting of over 300 insurance companies that write over 80% of the health insurance in the United States today. Please accept this memorandum as our testimony in regard to H.B. 2171. Initially, when this bill was requested by the Chiropractic Association their explanation of the bill asserted that the legislation is needed to provide some additional and/or new policing powers against insurance companies who fail to abide by the various mandate laws enumerated in Chapter 40. Without knowing specific instances as to what it is they are attempting to correct, it is difficult at best to address this particular bill. However, the bill appears to be extremely broad and far-reaching, and as such we respectfully request that this Committee scrutinize this bill very carefully, and after hearing testimony of the proponents, if it is determined that there is a particular problem we would be most happy to work with the legislature in attempting to resolve the specific problem that is alleged by the Chiropractic Association.

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First, it is a given fact that the various mandate laws found in Chapter 40 must be abided by in all insurance policies. Thus, it is illegal for an insurance company to file a health insurance policy with the Insurance Department that in any way would violate the required mandates. Therefore, from a filing point of view there is enormous power in assuring that such mandates are included in the policy, that power being that the Kansas Insurance Department simply would refuse to approve the filing. If an insurance company utilizes a policy form that has not been approved for filing, there are various administrative procedures which the Insurance Department may take against the insurance carrier which made the erroneous filing.

Next, we have grave concern as to how new section two and new section three can be read in concert. New section two basically states that no entity to which the Act applies shall avoid, evade, circumvent or otherwise attempt to elude compliance of the mandates by imposing conditions or using other contractual means on covered treatments or services. However, new section three states that nothing in this Act shall be construed to prohibit the application of deductibles, co-insurance, etc. We are uncertain as to what action the chiropractors are attempting to cease under new section two inasmuch as the various "managed care" applicabilities are found in new section three.

Further, if the policy does provide for coverage of these mandates and/or services, failure to pay for those coverages or services is <u>currently</u> a violation of the Unfair Trade Practices Act. Thus, it would appear that without a better explanation as to what

exactly new section three is attempting to stop, we are curious as to why new section four is needed at all.

My client has a grave concern that this bill is an attempt to utilize the mandate laws in such a fashion as to avoid managed care types of procedures, whether deductibles, utilization review, etc. If that were the ultimate result of this particular piece of legislation, it would most likely do nothing but increase the cost of health care within the insurance component. As everyone is well aware, health care costs are at the forefront of review by the federal government and state governments. We would urge this Committee to act cautiously in approving any bill that in any manner may increase the ultimate health care costs.

Again, if there is a specific problem in the marketplace that needs to be dealt with concerning the chiropractors, we would be most happy to work with them and the Kansas Insurance Department. We again urge prudence by this Committee in reviewing such a broad and potentially over-reaching piece of legislation, and would respectfully request that this Committee move cautiously on this bill.

Based upon the information we have, my client respectfully requests that the Committee act disfavorably on this bill. I appreciate the opportunity to appear before the Committee, and if you have any questions, please feel free to contact me.

Respectfully submitted,

William W Sneed

William W. Sneed

TE OF KANSAS

KANSAS STATE EMPLOYEES
HEALTH CARE COMMISSION

COMMISSIONERS:
Robert C. Harder, Cha...
Ron Todd
Susan M. Seltsam

Dave Charay,
Benefits Administrator

# MEMORANDUM

TO: Members of the House Financial Institutions and Insurance

FROM: Dave Charay, Health Benefits Administrator

DATE: February 10, 1993

SUBJECT: Testimony on HB 2171

Mr. Chairman, members of the Committee, thank you for the opportunity to present testimony in opposition to HB 2171. My name is Dave Charay. I am the health Benefits Administrator for the Kansas State Employees Health Care Program. On behalf of the Kansas State Employees Health Care Commission, I am appearing today in opposition to HB 2171.

As introduced, HB 2171 would eliminate the option of insurance companies to offer limited networks such as Preferred Provider Organizations (PPOs), Health Maintenance Organization (HMOs), etc. Provider networks are one of the few effective ways to control the rising cost of health care services and health insurance benefits offered to our active and retired employees.

The spiralling cost of health care and health insurance have been the focus of legislative and media attention for several years. Managed care networks have shown themselves to be a cost effective means of providing access to necessary medical care. The Health Care Commission has adopted the philosophy of "managed care" and has promoted managed care programs in any health plan offered to state employees. Limited networks allow our insurance and HMO providers to negotiate for quality and cost standards. This bill is completely counter to the initiatives that have been taken in the past by the State of Kansas to encourage managed care network availability to Kansas residents and would have a severe, adverse effect upon future cost for the State benefits program.

Medical inflation trends projections are running at approximately twenty percent per year. Passage of HB 2171 would probably cause these trend projections to increase markedly.

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Landon State Office Building, Room 553-S., 900 S.W. Jackson, Topeka, Kansas 66612-1251, (913) 296-7483, fax (913) 296-2664

The total cost of the Kansas State Employees Health Care Program for calendar year 1992 was $133,123,000. Projections for the 1993 calendar year are approximately 160 million dollars. Of the $133.5 million paid in 1992, sixty-six percent or over $110 million was paid by the State of Kansas. The above costs reflect an estimated savings of over $15 million due to price reductions of contracting network providers.

With the limited networks which are in place at the present, the Health Care Commission is projecting a trend increase of twenty percent for future plan years. Elimination of cost effective network options would increase these cost and obligations significantly. Therefore, we urge you to oppose HB 2171.

DC:bcl

cc: Health Care Commission -
Robert C. Harder
Judy B. Rickerson
Richard E. Roberts
Susan M. Seltsam
Ron Todd

[As Amended by House Committee of the Whole]

*Session of 1991*

# HOUSE BILL No. 2590

By Committee on Appropriations

3-19

AN ACT relating to insurance; prohibiting discriminatory provisions in health and accident policies between certain ~~providers of~~ health care [providers and facilities] and providing penalties for violations; amending K.S.A. 40-19a10 and 40-19b10 and K.S.A. 1990 Supp. 40-19c09 and 40-19d10 and repealing the existing sections.

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

New Section 1. This act shall apply to all insurance companies, health maintenance organizations, nonprofit medical and hospital service corporations, nonprofit dental service corporations, nonprofit optometric service corporations, and nonprofit pharmacy corporations issuing, delivering or renewing insurance policies, subscriber contracts or certificates of insurance within or outside this state or used within this state by or for an individual who resides or is employed in this state.

New Sec. 2. No entity to which this act applies shall avoid, evade, circumvent or otherwise attempt to elude compliance with the provisions of K.S.A. 40-2,100, 40-2,101 and 40-2,104 and K.S.A. 1990 Supp. 40-2,114 and 40-2250, and amendments thereto, by imposing conditions or using contractual provisions to exclude, describe or arrange for treatment of a covered condition or delivery of a covered service the effect of which is to deny payment or benefits for covered services lawfully performed within the scope of any license, registration or certificate of the health care personnel identified in the statutory provisions referenced in this section.

New Sec. 3. Nothing in this act shall be construed to prohibit the application of deductibles, coinsurance, cost containment or quality assurance measures, or contractual arrangements the purpose of which is to promote or require a more efficient use of health care services if such provisions and arrangements are equally applied to all types of health care personnel referred to in the statutory provisions cited in section 2 without discrimination to the usual, customary and lawful procedures of any type of medical care provider [or if the application of such deductibles, coinsurance, cost containment or quality assurance measures or contractual arrangements depend upon the insured's use of a primary care physician or adherence to the protocols of a managed care or coordinated care insurance arrangement].

[New Sec. 4. No individual or group policy of accident and sickness insurance providing coverage for reimbursement or indemnity for diagnosis or treatment of mental and nervous conditions, as defined by K.S.A. 40-2,105, and amendments thereto, in any medical care facility shall exclude reimbursement or indemnity under such policy for such services when performed at Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital. The provisions of this section shall also be applicable to contracts issued by health maintenance organizations.]

New Sec. 4 [5]. Violations of this act shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

New Sec. 5 [6]. The commissioner of insurance may promulgate such rules and regulations as are necessary to carry out the provisions of this act.

Sec. 6 [7]. K.S.A. 40-19a10 is hereby amended to read as follows: 40-19a10. Such corporations shall be subject to the provisions of *sections 1 to 5, inclusive, of this act and to the provisions of* K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2a01 to 40-2a19, inclusive, 40-2216 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, 40-3301 to 40-3313, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 7 [8]. K.S.A. 40-19b10 is hereby amended to read as follows: 40-19b10. Such corporations shall be subject to *sections 1 to 5, inclusive, of this act and to the provisions of* K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,102, 40-2a01 to 40-2a19, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3312, inclusive, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

Sec. 8 [9]. K.S.A. 1990 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit

Senate Insurance
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PROPOSED BILL NO. ____

AN ACT relating to credit unions; concerning expulsion of members; confidential information; credit union council; amending K.S.A. 1992 Supp. 17-2219, 17-2227 and 17-2232 and repealing the existing sections; also repealing K.S.A. 1992 Supp. 17-2232a.

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

Section 1. K.S.A. 1992 Supp. 17-2219 is hereby amended to read as follows: 17-2219. (a) ~~Subject--to--the--provisions--of subsection--(b),-the-members,-by-2/3-vote-of-those-present-at-any regularly-called-meeting,-may-expel-from--the--credit--union--any member.~~ Any member may be expelled from the credit union:

(1) By a 2/3 vote of the members present at any regularly called meeting of the membership; or

(2) in accordance with the provisions of subsection (b), by the board of directors for a member's abuse of member account privileges, a member's act or failure to act which causes financial loss to the credit union, or a member's failure to purchase shares and utilize loan or other services of the credit union. The board of directors shall report the expulsion of a member at the next regularly scheduled members' meeting.

(b) The board of directors of a credit union may adopt a policy with respect to expulsion from membership for any reason set forth in paragraph (2) of subsection (a). If such a policy is adopted, written notice of the policy as adopted and effective date of such policy shall be mailed to each member of the credit union at the member's current address appearing on the records of the credit union not less than 30 days prior to the effective date of such policy. In addition, each new member shall be provided written notice of any such policy prior to or upon applying for membership. The board of directors of a credit union shall provide the member with a notice of expulsion from the

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membership not less than 30 days prior to the effective date of the expulsion. Within the thirty-day period, the member, by written request, may require the board of directors to bring the member's expulsion before the credit union membership at the next regularly scheduled members' meeting. If the member makes such written request, the board of directors' expulsion of such member shall be delayed until the credit union membership votes on such member's expulsion as provided under subsection (a).

~~In--establishing--its--policy,--the--board--should-consider-a member's:~~

~~(1)--Failure-to-vote-in-annual-credit-union-elections;~~

~~(2)--failure-to-purchase-shares-from-and-obtain-a--loan--from or-lend-to-the-credit-union;~~

~~(3)--abuse-of-member-account-privileges;~~

~~(4)--act-or-failure-to-act-which-causes-financial-loss-to-the credit-union.~~

~~If--such-a-policy-is-adopted,-written-notice-of-the-policy-as adopted-and-the-effective-date-of-such-policy-shall-be-mailed--to each--member--of-the-credit-union-at-the-member's-current-address appearing-on-the-records-of-the-credit-union--not--less--than--30 days--prior--to--the-effective-date-of-such-policy.---In-addition, each-new-member-shall-be-provided--written--notice--of--any--such policy-prior-to-or-upon-applying-for-membership.~~

~~(c)--In--addition--to--the--provisions-of-subsection-(a),-the board-of-directors,-subject-to-the-provisions-of-subsection--(b), may--expel--a--member--for--a--member's--abuse--of-member-account privileges-or-a-member's-act--or--failure--to--act--which--causes financial--loss-to-the-credit-union.-The-board-of-directors-shall report-the-expulsion-of-a-member-at-the-next-regularly--scheduled member's-meeting.~~

~~(d)~~ (c) A member may withdraw from a credit union, as hereinafter provided, by filing a written notice of such intention. All amounts paid on shares of an expelled or withdrawing member, with any dividends credited to the member's shares to the date of expulsion, or withdrawal, shall be paid to the member, but only as funds become available and after

deducting any amounts due to the credit union by the member. All shares of an expelled or withdrawing member, with any interest accrued, shall be paid to the member, subject to 60 days' notice, and after deducting any amounts due to the credit union by the member. The member, when withdrawing shares, shall have no further right in the credit union or to any of its benefits, but such expulsion or withdrawal shall not operate to relieve such member from any remaining liability to the credit union.

Sec. 2. K.S.A. 1992 Supp. 17-2227 is hereby amended to read as follows: 17-2227. ~~The--administrator--and-all-employees-and deputies-may-give-information-secured-from-or-about-credit-unions to-corporations-composed-solely-of-credit-unions-formed-under-the provisions-of-the-act-of-which-this-act--is--amendatory--for--the purpose--of--protecting--the--solvency--of--such-credit-unions-or otherwise-assisting-such-credit--unions--in--complying--with--the legal--requirements--imposed--upon--them.---The-administrator-may provide-information-regarding-credit-unions-to-the--administrator of--the--national--credit-union-administration-for-the-purpose-of the-availability-of-the-national-credit-union-insurance--fund--to such--credit--unions.-The-administrator-shall-provide-information to-the-private-insurer-of-any-credit-union-regarding--the--credit union-insured-by-such-insurer.-The-administrator-may-also-provide such--information--to--the--credit--union's--bonding-company.-All information-which-the-administrator-shall--gather--or--record--in making--an-investigation-or-examination-of-any-credit-union-shall be-deemed-to-be-confidential-information-and,-except-as-otherwise authorized-in-this-act,-the-administrator-and-all--employees--and deputies--shall-not-otherwise-divulge-any-information-acquired-by them-concerning-any-credit-union-in-the-discharge-of-their-duties as-prescribed-by-this-act-except--insofar--as--the--same--may--be rendered--necessary--by-law-and-the-carrying-out-of-the-duties-of the-officials-or-under-order-of-the-court-in-an-action--involving credit-unions-or-in-criminal-actions.~~ (a) All information secured or produced by the administrator in making an investigation or examination of any credit union shall be deemed confidential information.

(b) All such confidential information shall be the property of the state of Kansas and shall not be subject to disclosure except upon written approval of the administrator.

(c) Confidential information may be disclosed to federal or state agencies when necessary in the performance of their official duties or functions. No employees of such agencies may disclose such confidential information without express written authorization of the administrator.

(d) Confidential information may be disclosed to the private insurer of any credit union regarding the credit union insured by such insurer when necessary in the performance of their official duties or functions. No employees of such private insurer may disclose such confidential information without express written authorization of the administrator.

(e) Confidential information may be released to other third parties if, in the administrator's determination, good cause exists for the disclosure. The administrator shall give prior notice of intent to disclose such information to the affected credit union. No person or other third party may disclose such confidential information without express written authorization of the administrator.

(f) Confidential information shall not otherwise be disclosed except as rendered necessary by law or under order of the court in an action involving credit unions or in criminal actions.

Sec. 3. K.S.A. 1992 Supp. 17-2232 is hereby amended to read as follows: 17-2232. (a) The governor shall appoint a seven-member credit union council. Each member shall be a resident of Kansas. Appointments to the council shall be for terms of three years. Persons appointed to the council ~~on--or after-July-1,-1982,~~ shall be ~~appointed~~ subject to confirmation by the senate as provided in K.S.A. 75-4315b, and amendments thereto. Five of the persons appointed shall be members in good standing and officers of Kansas state chartered credit unions ~~and shall-each-reside-in-a-different-congressional-district~~. Subject to the provisions of K.S.A. 1992 Supp. 75-4315c, and amendments

thereto, of those five members, the governor shall appoint one from each congressional district and the remainder from the state at large. The council shall elect annually a chairperson, a vice-chairperson and a secretary for a term of one year ~~and~~ or until their successors have been appointed and qualified. All members of the council shall serve until their successors have been appointed and qualified. ~~Only~~ Kansas state chartered credit unions regulated under the provisions of this act may submit annually to the governor, for consideration in making appointments to the credit union council, a list of persons having the prescribed qualifications for membership on the council. The council may adopt such rules and regulations governing the compilation of such list as may be necessary. Vacancies on the council shall be filled for the unexpired term by appointment by the governor. No person shall serve more than two consecutive terms as a member of the council. No more than four members of the council shall be from the same political party.

(b) Council meetings shall be on call of a majority of the council or the chairperson. The council shall hold one regular meeting during each quarter of the year, upon such dates and at such places as designated by the council, and may hold such other meetings as the council considers necessary. The majority of the council shall constitute a quorum for doing business. The council may adopt such rules as advisable for conducting business and, until otherwise changed or modified, the council shall abide by ~~Roberts~~ Robert's rules of order in conducting business.

(c) The council shall serve as an advisor to the administrator on issues and needs of credit unions.

Sec. 4. K.S.A. 1992 Supp. 17-2219, 17-2227, 17-2232 and 17-2232a are hereby repealed.

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

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