Approved: March 16, 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 March 11, 1993 in Room 527-S of the Capitol.

All members were present except:

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

Conferees appearing before the committee: Dick Brock, Insurance Department
William Sneed, State Farm
Robert Epps, SRS
Jerry Banka, Kansas Life Association

Others attending: See attached list

**Hearing on SB 22:** Waiver of premiums for unemployment on life insurance policies

Dick Brock of the Insurance Department provided testimony supporting this bill which would permit life insurers to incorporate a waiver of premium provision for periods of unemployment in products marketed in this state (Attachment 1). Specifics would be spelled out in the contracts and the option would be available if insurers are willing to offer it and the insurees want to buy it.

**Hearing on SB 25:** Penalties under regulation of insurance trade practices

Dick Brock, Insurance Department, presented testimony which would amend the penalty provisions of the body of law commonly referred to as the Unfair Trade Practices Act which defines unacceptable behavior by insurance companies, agents and other persons involved in such transactions (Attachment 2). This bill addresses the situation of the Insurance Department resolving disputed claims situations and redressing the injury whether or not an unfair claim settlement practice has been committed. Interest and/or costs incurred by the consumer as well as the refund of premiums, is addressed by this amendment.

Bill Sneed, State Farm, presented the following comments regarding the proposed amendment:

1. Suggested that the language in the interest rate provision should be stated "should not exceed ___%."

2. When interest is to begin is not addressed: should it be at the time of injury, time of claim, time of denial of claim? He recommended that interest should begin no earlier than when the company issues the letter of dispute.

3. Suggested that reasonable costs should mean the actual cost of the claimant in filing the claim with the Commissioner.

**Hearing on SB 26:** Annual statements of condition of insurance companies

Dick Brock, Insurance Department, stated that this amendment would require the filing of an annual financial statement of insurers in accordance with regulations set out by the National Association of Insurance Commissioners (Attachment 3). Any non-conformity to requests for this or additional information will be initiated by the Commissioner as opposed to insurers.

**Hearing on SB 23:** Continuity of coverage of accident and sickness insurance

Dick Brock, Insurance Department, stated this bill would require every group health insurance policy,

certificate, contract and subscriber agreement to contain a contractual provision to extend the payment of benefits for at least 31 days following expiration of the policy for covered persons confined in a hospital on the date the coverage would otherwise terminate (Attachment 4). Mr. Brock proposed an amendment in which the replaced insurer would be relieved of its obligation under its contract if the person was discharged prior to the end of the 31 day extension. Any subsequent admission would be the responsibility of the "new" insurer. This would apply to nonprofit medical and hospital service corporations and HMOs. This does not apply when moving from a group to an individual policy.

**Hearing on SB 24:** Group accident and health insurance, number of employees for coverage

Dick Brock of the Insurance Department reviewed legislation from 1991 (HB 2001 and SB 561) regarding qualifications relating to the minimum size for group sickness and accident insurance of an individual employer or member unit within a multiple employer trust or association (Attachment 5). This legislation required a minimum of 5 or more employees as a precondition to membership in the trust or association. Employer units of 3 to 5 employees could be precluded from receiving the benefit of the 1991 legislation. The proposed legislation would reduce the statutory eligibility criteria for a single employer group from 5 to 3 thereby enabling units of a trust or association with 3 or more employees eligible for guaranteed issue of group coverage.

**Hearing on SB 321:** Accident and health insurance; effect on medicaid coverage

Robert Epps, Commissioner of Income Support/Medical Services of SRS, stated that the amendments in this bill are needed to protect the taxpayers of Kansas from the loss of federal matching funds for the operation of the Kansas Medicaid Program in providing services to those individuals and families who are temporarily dependent (Attachment 6).

Jerry Banaka, a director of Kansas Life Association, suggested several amendments appearing in Attachment 7. Commissioner Epps was asked to review the proposed amendments regarding the meeting of federal requirements.

Representative Kline moved to include all the amendments requested by the Kansas Bankers Association in SB 35. Representative Bruns seconded the motion. The motion carried. Representative King moved for the favorable passage of the bill as amended. Motion seconded by Representative Minor. Motion carried.

Representative Dawson moved to amend SB 34 into SB 37 and for the favorable passage of the amended bill. The motion was seconded by Representative Allen. Motion carried.

Representative Cornfield moved that all technical corrections be made by the Revisor's Office in SB 139 and that an amendment be added to make the effective date the date of its publication in the Kansas Register. Representative Gilbert seconded the motion. The motion carried. Representative Minor moved for the favorable passage of the bill as amended. Representative Cornfield seconded the motion. The motion carried.

Representative Gilbert moved for the approval of the minutes of March 10, 1993. Representative Allen seconded the motion. The motion carried.

The meeting adjourned at 4:40 p.m. The next scheduled meeting is March 15, 1993.

# GUEST LIST

COMMITTEE: J & D DATE: 3/11/93

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATIO |
|---|---|---|
| DAVID THORNBURG | 1133 TOPEKA BLVD | KANSAS GROUP LIFE |
| BARBARA STANSBURY | 1133 TOPEKA BLVD | KANSAS GROUP LIFE |
| Robert Epps | Topeka | SRS |
| CHARLES WALKER | Topeka | SRS |
| Jim Maag | | |
| Dick Brock | | |
| Jerry Banaka | | |
| Bill Sneed | | |
| Bill Henry | | |
| DAVID A. ROSS | TOPEKA | KANSAS ASSN. LIFE UNDERWRITERS |
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Testimony on
Senate Bill No. 22
by
Dick Brock
Kansas Insurance Department

Some life insurance companies are now marketing products which include a waiver of premium provision if the insured becomes unemployed. Current Kansas law does not permit the inclusion of this provision in policies issued in this state. Senate Bill No. 22 would alleviate this problem by specifically permitting life insurers to incorporate a waiver of premium provision for periods of unemployment in products marketed in this state.

The precise period of unemployment and extent of the premium waiver would be spelled out in the contract. Therefore, it would no doubt vary depending on the type of contract and, of course, different insurers would probably impose different requirements and different waivers. However, as an example, a trade press report indicates that one prominent life insurer requires the insured to have been employed for at least 2 consecutive years (not necessarily at the same job), own the policy for at least a year and be unemployed for 60 days. If the insured meets these requirements, the company will waive the premium for a year even if the period of unemployment is only a few months. The cost of this benefit is 4% of the total premium for the policy including charges for other riders.

We are not aware of any consumer demand for this type of benefit. Nevertheless, it seems to us that Kansas life insurance buyers should have this option available if insurers are willing to offer it and they want to buy it.

House Financial Institutions & Insurance
March 11, 1993
Attachment 1

Testimony on
Senate Bill No. 25
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 25 amends the penalty provisions of the body of law commonly referred to as the Unfair Trade Practices Act. Generally speaking, these statutes define acts which constitute unacceptable behavior by insurance companies, agents and other persons involved in insurance transactions. Misrepresentation, false advertising, unfair claim settlement practices and other actions detrimental to the insuring public are prohibited by these statutes. Because of the significance of these statutes in the regulation of market conduct, there are several different types of penalties the Commissioner may impose ranging from a simple cease and desist order to license revocation. Included in these penalty options is a provision which permits the Commissioner to order redress of the injury and this is the provision affected by Senate Bill No. 25. Redress of the injury may, of course, take different forms. For example, in cases of false advertising, it is not unusual for an insurer or agent to be ordered to direct a letter to all persons purchasing the advertised product offering an unconditional refund of all premium paid. The Department contacts a random sample of the people who were supposed to receive the letter to see if, in fact, compliance with this part of the order was achieved.

Redress of the injury may also occur in claim situations. Because the Insurance Department has a very active and aggressive Consumer Assistance Division, the vast majority of disputed claims involve differences of opinion as to value, extent of insured damage and other common disagreements. Therefore, they are handled informally and do not fall within the parameters of the unfair claim settlement provisions of the Unfair Trade Practices Act. In addition, until an amendment was enacted last session, a violation of the unfair claims settlement provisions did not exist unless the forbidden act was committed with such frequency as

Insurance 7-b-1
Attachment 2
March 11, 1993

to constitute a general business practice. With the 1992 amendment, a single act may now be a violation if it is flagrant or in conscious disregard of the unfair claim settlement practices described in the statute.

I present this background because there is often a misperception that every insurance claim in which the Department becomes involved is or should be the subject of a formal proceeding under the unfair claims settlement provisions of the Unfair Trade Practices Act. This is not the case.

On the other hand, it is reasonable to assume that the existence of these statutory provisions and the related penalty options encourages insurance company cooperation in many claim situations addressed by our consumer assistance representatives. As a result, without incurring the expense or delay formal proceedings would require, the Department is able to resolve disputed claims situations and, in effect, redress the injury whether or not an unfair claim settlement practice has been committed. One area that has been the subject of some dispute both informally and otherwise is whether "... redress of the injury by requiring the refund of any premiums paid by, the payment of any moneys withheld from, any consumer ..." is intended to include interest and/or costs incurred by the consumer that would not have been necessary if the claim or other grievance had been properly addressed in the first place.

Senate Bill No. 25 will clarify this issue by adding the new sentence to subparagraph (3) subsection (a) of 40-2407.

Testimony on
Senate Bill No. 26
by
Dick Brock
Kansas Insurance Department

Senate Bill No. 26 amends the statute which requires the filing of an annual financial statement by insurers. This statute, K.S.A. 1991 Supp. 40-225, also requires the form of such statement to be that adopted by the National Association of Insurance Commissioners (NAIC). Presumably requiring the statement to conform to the NAIC "blank" contemplates that it will be prepared in accordance with the instructions and accounting procedures and practices that are also prescribed by that organization. This proposal would simply include such requirement in the statute.

K.S.A. 40-225 includes latitude which permits the Commissioner to require such additions or amendments as the Commissioner deems necessary to elicit from insurers a true exhibit of their financial condition. Therefore, even with the required NAIC form, instructions, practices and procedures, the Commissioner can still accommodate unusual or unique situations. However, the statutory requirement better assures that any non-conformity will be initiated by the Commissioner as opposed to insurers.

House Financial Institutions & Insurance
Attachment 3
March 11, 1993

Testimony on
Senate Bill No. 23
by
Dick Brock
Kansas Insurance Department

Although it requires a somewhat unusual combination of events, it is not uncommon for an individual to experience a "gap" in health insurance coverage when a group changes insurance carriers. This occurs because the contract of each carrier includes provisions relating to the date and time coverage commences and the date and time coverage terminates. However, different carriers use different provisions. Consequently, a person may have had group health insurance coverage continuously over a long period of time yet, because the effective date and time of a new contract does not coincide with the termination date and time of a replaced contract, find themselves without coverage for a period of time ranging from a few hours to several weeks. Although these situations can usually be rectified through negotiations with the carriers involved if the situation is brought to the Insurance Department's attention, the subscriber(s), enrollee(s) and certificateholder(s) affected are exposed to a great deal of anxiety. Also, there are probably some who simply and begrudgingly accept the consequences rather than seek assistance from the Insurance Department, group sponsor or some other source.

Although insurance companies, health maintenance organizations, and nonprofit medical and hospital service corporations probably prefer their own contractual provisions, this is a situation where the public interest requires continuity. Therefore, Senate Bill No. 23 would require every group health insurance policy, certificate, contract and subscriber agreement to contain a contractual provision as specified in subsection (a) of New Section 1 which extends the payment of benefits for at least 31 days following expiration of the policy for covered persons confined in a hospital on the date the coverage would otherwise terminate. Subsequent to Senate Committee action on the bill, it was noted that this flat 31 day extension could have an unintended result in certain

House Financial Svcs
March 11, 1993
Attachment 4

situations. Specifically, under the bill as currently written, if a person is discharged but re-admitted during such 31 day extension, the initial or replaced insurer would still be obligated to provide coverage for the remainder of the 31 day period even though it had already provided benefits for the hospital confinement that began under its contract. To prevent this unintended effect, I have attached to my testimony a proposed amendment. With this amendment, the replaced insurer would be relieved of its obligation under its contract if the person was discharged prior to the end of the 31 day extension. Any subsequent admission would be the responsibility of the "new" insurer.

In either event, the succeeding or replacement contract would, pursuant to subsection (b) of New Section 1 become effective immediately upon expiration of the previous contract. However, benefits provided under the previous contract by virtue of the required extension for inpatient coverage would not be payable under the new policy. The reason for this distinction is that less confusion would result and the third party payors could better administer the benefits if the carrier insuring the patient continued to provide the coverage until the insured person is released from the hospital. The maximum 31 day extension will not have this result in all cases but it certainly should accommodate the vast majority. With respect to outpatient or other covered services, the requirement imposed by subsection (b) will assure that coverage is in effect even though changes in deductibles, coinsurance features and other contractual differences may prevent immediate payment of benefits. Problems of this nature are, however, a result of changes in coverage and would occur regardless of whether the time coverage becomes effective and terminates is coordinated between the 2 contracts and could even occur when the contract changes but the carrier remains the same.

Sections 2 and 3 of the proposal are effectively identical to New Section 1 and simply impose the same requirements on nonprofit medical and hospital service corporations and HMOs respectively.

Session of 1993

# SENATE BILL No. 23

By Committee on Financial Institutions and Insurance

1-15

AN ACT concerning insurance; accident and sickness insurance; continuity of coverage; amending K.S.A. 1992 Supp. 40-19c09 and 40-3209 and repealing the existing sections.

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

New Section 1. Every group policy and certificate of accident and sickness insurance providing inpatient hospital, medical-surgical benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall:

(a) Contain a provision extending payment of such benefits for a period not less than 31 days following the expiration date of the policy for covered insureds confined in a hospital on the date of termination; and

(b) provide that coverage under any subsequent replacement policy, contract or certificate that is intended to afford continuous coverage will commence immediately following expiration of any prior policy, contract or certificate with respect to benefits not paid or payable under subsection (a).

Sec. 2. K.S.A. 1992 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of ~~K.S.A. 1992 Supp. 40-2253~~ *section 1 of this act*, 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, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, and amendments thereto, and to the provisions of K.S.A. 1992 Supp. 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250 ~~and~~, 40-2251 *and 40-2253*, 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.

until discharged or

whichever is earlier

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Testimony on
Senate Bill No. 24
by
Dick Brock
Kansas Insurance Department

Both 1991 House Bill No. 2001 and 1992 Senate Bill No. 561 relied on the long-standing statutory qualifications for group sickness and accident insurance. Consequently, for the underwriting prohibitions, rating restrictions and other insurance reforms included in the bills to apply, a single employer was and is still required to insure at least 5 employees; an association must insure at least 25 members; a trust must consist of 2 or more employers or business associations and so forth.

One change that was incorporated in Senate Bill No. 561 was a new qualification relating to the minimum size of an individual employer or member unit within a multiple employer trust or association. Historically, trusts and associations have been used simply as a means of providing access to group health insurance by small employers who do not have a sufficient number of employees to qualify as an independent group. Once the trust or association group is formed, however, each employer unit has, in actual practice, been generally treated as a separate, free-standing group for rating and underwriting purposes.

The group health insurance reform measures included in 1991 House Bill No. 2001 and 1992 Senate Bill No. 561 necessitated a change in this traditional practice. The underwriting prohibitions, rating restrictions and guaranteed issue mechanism included in that legislation required a more specific definition of the sets and subsets of individuals to whom the requirements apply. Consequently, Senate Bill 561 imposed a secondary eligibility requirement on trust and association groups by providing that the member units of such groups must consist of 3 or more employees. For purposes of group eligibility, the employer is counted as an employee. However, it now appears we may have inadvertently provided a way for insurers to circumvent some of the intended reforms. The

House F. & D.
Attachment 5
3-11-93

intent was to apply the underwriting prohibitions, rating restrictions and guaranteed issue requirements to all employer groups with 3 or more employees. However, by arbitrarily requiring a minimum of 5 or more employees as a precondition to membership in the trust or association, employer units of 3 to 5 employees could be precluded from receiving the benefit of the 1991 and 1992 legislative action. The most effective remedy is to simply reduce the statutory eligibility criteria for a single employer group from 5 to 3. By so doing, member units of a trust or association consisting of 3 or more employees will be eligible for guaranteed issue of group coverage and have the other protections now applicable to health insurance groups either as a participant in a trust or association or as a single employer. As a result, insurers could not realize an advantage by strategic changes in a trust or association's eligibility requirements. This simple change appears in subparagraph 1 of subsection (A) of section 1.

**KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES**
**Donna L. Whiteman, Secretary**

**House Financial Institutions and Insurance Committee**
**Testimony on Senate Bill 321**

**March 11, 1993**

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**SRS Mission Statement**

**"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."**

**********

Mr. Chairman, Members of the Committee, on behalf of Secretary Donna L. Whiteman, thank you for this opportunity to address you in support of Senate Bill 321. The amendments contained in this bill are needed to protect the taxpayers of Kansas from the loss of federal matching funds for the operation of the Kansas Medicaid Program in providing services to those individuals and families who find themselves temporarily dependent on their fellow Kansans for assistance.

The Medicaid (Medical Assistance) Program was created in 1965 by enactment of Title XIX of the Social Security Act (the Act). From it's inception, Congressional intent is clear that Medicaid is to pay for the cost of care for which Medicaid eligibles would have to pay themselves if Medicaid were not available. To further clarify the intent of Congress, the Act was amended in 1967 by Public Law 90-248 and provides that Medicaid only pays after the liability of third parties to pay for medical care has been exhausted.

In the years that followed, Congress found that not all states were responsive in assuring the last payer status of the Medicaid Program. To further stress the intent of Congress, in 1977 the Medicare and Medicaid Antifraud and Abuse Amendments were passed. Contained in those amendments was a provision that denies Federal Financial Participation (FFP) for expenses which could have been paid for under private insurance contracts except for a provision in the contract limiting or excluding payment due to eligibility for or receipt of Medicaid benefits. It was felt that the provision would provide incentive to States to modify their insurance laws.

The need for this legislation is real. It benefits not only the clients we serve, but all Kansans. It conveys the legislature's concern for the rights and dignity of the people of Kansas. The Department of Social and Rehabilitation Services encourages and supports the passage of Senate Bill 321.

Robert L. Epps
Commissioner
Income Support/Medical Services

House Financial Institutions & Insurance
March 11, 1993
Attachment 6

# Kansas Life Association



L. M. Cornish
General Counsel
900 Merchants Natl. Bank Bldg.
Topeka, Kansas 66612

March 11, 1993

REPRESENTATIVE WILLIAM BRYANT
CHAIRMAN
FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
STATEHOUSE
TOPEKA KANSAS

Re: SB 321

Dear Sir:

We wish to offer amendments to SB 321.

SB 321 requires insurance companies writing accident and sickness policies that are subject to K.S.A. 40-2203 (individual policies) to include in their policies the following provision:

> "Medicaid: If there be valid medicaid coverage, providing benefits for the same loss, the medicaid coverage shall be considered the payer of last resort."

Senate Bill 321 also subjects insurance companies writing group accident and sickness policies under K.S.A. 40-2209 to the same requirement.

Senate Bill 321 provides that insurance companies subject to this requirement may show this provision by an endorsement stamped upon the policy, by a rider stating the provision or by inclusion in the printed policy.

Senate Bill 321 prohibits non-profit corporations writing accident and sickness insurance from including in their policies and related forms a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by Title XIX of the Social Security Act of 1965 are or may be available for the same accident or illness.

House Ins. Comm.
Attachment 7
March 11, 1993

However, there is no requirement that the policies of these non-profit corporations be amended or revised to specifically include the provision required of companies subject to K.S.A. 40-2203 and 40-2209. The intent throughout the bill covering this medicaid issue is the same but the manner in which this issue is addressed differs.

We respectfully suggest the manner by which the medicaid provision is handled for non-profit corporations will work for all insurers covered by Senate Bill 321 and it would eliminate the time and expense associated with amending or revising, at least, some of the accident and sickness contracts of those companies subject to K.S.A. 40-2203 and 40-2209.

We, therefore, suggest the following amendments:

Page 9: Strike lines 41 through 43.
Page 10: Strike lines 1 and 2.
Page 15: Insert new subsection (H) on line 21, as follows:

"(H)(1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.
(2) Violation of subsection (H)(1) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto."

Page 18: Strike lines 11 through 15.

Insert new subsection (D) beginning on line 23.

"(D)(1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.
(2) Violation of subsection (D)(1) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto."

Page 18: Change existing subsection (D) to (E) on line 23.

We appreciate the opportunity to suggest these amendments.

Cordially yours,

JERRY BANAKA