Approved: March 7, 1994
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 21, 1994 in Room 527-S of the Capitol.

All members were present except: Representative George Teagarden, Excused

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

Conferees appearing before the committee: Jerel Wright, Kansas Credit Union Association
Bud Cornish, Property & Casualty Insurance Association
George Barbee, KS Assoc. of Financial Services
Representative Carol Sader
Brent Schondelmeyer, concerned citizen
William Sneed, HIAA
Brad Smoot, AIA
Larry Magill, KAIA

Others attending: See attached list

**HEARING ON HB 2424: Increasing amount covered by credit life**

Jerel Wright, Government Affairs Director for the Kansas Credit Union Association, stated that the bill would increase the maximum amount of group credit life insurance from $50,000 to $100,000 (Attachment 1). Currently the maximum amount of insurance on the life of any debtor shall not exceed the amount owed by the debtor or $50,000, whichever is less. Due to real estate loans and the purchase of big ticket items, the current cap is too limiting. 32 states have no limits on group credit life insurance.

Bud Cornish, Minnesota Mutual Insurance Company, reiterated support for the bill.

George Barbee, Kansas Association of Financial Services, stated that due to dramatic changes in consumer finance loans, the amounts are exceeding the $50,000 limit which is a consumer benefit (Attachment 2). Regulations governing credit life insurance state that anyone under 65 years of age cannot be denied coverage unless they will turn 66 before the loan is scheduled to be paid off. The rate is the same for 30 and 60 year olds.

**HEARING ON HB 2917: Conversion notices, premium notices**

Representative Sader stated that the purpose of the bill was to clarify the responsibility for notification of termination of COBRA benefits by requiring the insurance company to provide notice to the insured terminated employee of the cancellation of COBRA coverage and a 30 day grace period (Attachment 3). The bill would also provide a limitation on the premium increase an insurer can charge on a conversation to a direct pay individual policy of not more than a 150% increase over the COBRA rate.

Brent Schondelmeyer reported that when the business he was working for closed, he lost his health insurance and no one told him or provided him at least 30 days to arrange for alternative coverage (Attachment 4). Federal COBRA law is very detailed in spelling out employer obligations and responsibility for letting terminated employees know about rights to elect COBRA coverage but both federal and state law remain unclear on whose responsibility it is to notify employees of the loss of COBRA coverage due to employer's cancellation of group health insurance. Mr. Schondelmeyer attempted to pay the COBRA coverage but his checks were returned with no explanation. Upon finally being notified after two months without coverage, he discovered a conversion policy would cost approxmately 600% more than the HMO he was carrying. This bill would:

1. Require the insurance company and the employer to provide notice of cancellation of COBRA coverage and a 30-day grace period.

2. Place a limitation on the premium increase an insurer can charge on conversion to a direct-pay individual policy.

William Sneed, HIAA, stated they had no opposition to inserting a notice requirement but most carriers already provide for notice (Attachment 5). He noted that the amendment which would allow for conversion from a group to an individual policy with a cap of 150% would not be appropriate. This cap would create an artifical rating system that would not accurately reflect the true components which generate the rate. They requested that the new language area on Page 5 lines 40 and 41 be deleted and current law be reinstituted.

**HEARING ON HB 3041: Repealing the reporting of certain information to the Commissioner of Insurance**

Copies of the original statue 40-1126,1127, 1128, and 1129 were distributed to Committee members (Attachment 6).

Brad Smoot, AIA, stated that this bill would repeal the statutes which require the monthly reporting of claims and premium data for professional liability insurance (Attachment 7). The average cost for the preparation of these reports is $3,000. This information is reported annually to the regulatory or licensing board of physicians, attorneys, hospitals, dentists, optometrists, engineers, architects, etc. There is no compilation, analysis or use for this data other than that prepared by the Insurance Department in the annual Report on the Health Care Provider Insurance Availability Act.

Dick Brock, Insurance Department, said there are no requests for this report and no one has indicated an objection to the proposed repeal.

Larry Magill, KAIA, supports the bill as it will make the insurance business more attractive to new insurance companies considering entering the Kansas market.

**ACTION ON HB 2633: Adverse underwriting decisions, health maintenance organizations**

This bill would impose the same obligations on HMO's as other insurers in that they must tell the applicant why they are being denied coverage.

Representative Cox moved to pass the bill out favorably. Motion seconded by Representative Correll. Motion carried.

**ACTION ON HB 2096: Accident and health insurance, payment of benefits**

This bill is an offshoot of SB 66 which was passed in 1992 which allowed BC/BS to contract with hospitals and touted as a health care cost containment for consumers. St. Francis Hospital of Wichita has indicated that bill was passed without their full knowledge. The case of St. Francis vs. BC/BS (right to contract) is now in the Appellate Court with a decision expected this summer.

Representative Wagle moved to amend HB 2096 with language which would allow a 10% difference between costs on contracting and non-contracting hospitals (Attachment 8). The clients using non-contracting hosptials would receive the checks direct or could receive the check with the hospital's name also appearing as part of the payee. The non-contracting patients would be billed 10% more than those attending contracting hospitals. Representative Helgerson seconded the motion.

Brad Smoot, BC/BS, said this amendment was not acceptable as it would reduce their position for contract negotiations. Representative Sebelius reported receiving information from Dave Charay, Kansas Employees Health Insurance, stating the significant negative impact this would have on the pending contract with state employees and BC/BS.

Representative Correll entered a substitute motion to table the bill due to the litigation now in process between St. Francis and BC/BS. Motion was seconded by Representative Watson. The vote was 10 yes, 6 no. Motion carried.

Representative Cox moved to accept the minutes of February 15, 1994. Representative Watson seconded the motion. The motion carried.

The meeting adjourned at 4:30 p.m. The next meeting is scheduled for February 22, 1994.

# GUEST LIST

COMMITTEE: House Fed DATE: 2/21

| NAME (PLEASE PRINT) | ADDRESS | COMPANY/ORGANIZATIC |
|---|---|---|
| Dick Brock | Topeka | Ins Dept |
| Bud Cornish | " | Minnesota Mutual |
| Jerel Wright | Topeka | Ks Credit Union Assn |
| Chuck Stones | " | KBA |
| Kaye Traudel | " | Ks Gov Consultant |
| Danielle Noe | Topeka | State Farm |
| Joe Furjanic | Topeka | KCA |
| BRENT SCHONDELMEYER | INDEPENDENCE, MO | |
| Bill Sneed | Topeka | HIAA |
| Bill Pitzenberger | Topeka | BCBS |
| Brad Smoot | " | " |
| George Barbee | " | KAFS |

Kansas Credit Union Association

*The trade association and financial services provider for credit unions*

*8410 West Kellogg*
*Wichita, Kansas 67209-1896*
*316-722-4251 800-362-2076*
*Fax 316-729-0857*

Testimony on House Bill 2424

concerning group life insurance policies

Presented to the

House Financial Institutions and Insurance Committee

February 21, 1994

Mr. Chairman and members of the Committee:

I am Jerel Wright, Governmental Affairs Director, for the Kansas Credit Union Association, here today to ask for your support of HB 2424 which amends K.S.A. § 40-433.

Increase in Insurance Cap

HB 2424 makes one change in Kansas law by increasing to $100,000.00 (page 3, line 5) the maximum amount of credit life insurance a creditor may offer through a group credit life insurance policy. Currently, the maximum amount of insurance on the life of any debtor shall not exceed the amount owed by the debtor or $50,000.00, whichever is less.

An increasing number of credit unions are providing real estate loans and the $50,000.00 cap falls far short of allowing full coverage for the loan.

Kansas Part of Minority with a Cap

Kansas is one of only eleven states which operate with a cap of $50,000.00 or less and four of these states have a higher limit for loans secured by real estate. Eight states operate with a cap between $50,000.00 and $200,000.00 while the vast majority operate with no cap. Thirty-two states have no cap including most of the states surrounding Kansas. (see attachment)

Change Made in 1988 to Protect the Debtor

The Kansas legislature adopted a significant change in 1988. Lawmakers mandated that when a creditor requires credit life insurance, the creditor shall notify the debtor that the debtor has the option to provide the insurance through their own policy (K.S.A. § 16a-4-109).

Thank you, Mr. Chairman, for allowing me to testify on HB 2424. I will stand for questions at your direction.

House F.I.&I.
Attachment 1
2-21-94

## GROUP CREDIT LIFE INSURANCE DOLLAR LIMITS

(1) $25,000 limit - (1) state

District of Columbia ($75,000 for loans secured by real estate)

(2) $40,000 limit - (4) states

Kentucky (maximum applies when loan is 10 years or less. Loans over 10 years, no maximum applies.)
Massachusetts
New Jersey ($75,000 for loans secured by real estate)
Vermont ($80,000 for loans secured by realestate)

(3) $50,000 limit - (6) states

Florida
Kansas
Louisiana
Maryland
Ohio
Texas ($125,000 for loans secured by real estate for first mortgages only)

(4) $55,000 limit - (1) state

New York ($110,000 for loans secured by real estate)

(5) $70,000 - (1) state

Virginia

(6) $75,000 - (2) states

Georgia
Idaho

(7) $80,000* - (1) state

Michigan (*$80,000 maximum amount for mortgage loans only is adjusted annually by the United States Department of Labor Consumer Price Index as computed for each calendar year)

## GROUP CREDIT LIFE INSURANCE DOLLAR LIMITS
**(Continued)**

(8) $100,000 - (2) states

Oklahoma
Pennsylvania

(9) $200,000 - (1) state

Iowa

(10) No Limits - (32) states

Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
Hawaii
Illinois
Indiana
Maine
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
North Dakota
Oregon
Rhode Island
South Carolina
South Dakota
Tennessee
Utah
Washington
West Virginia
Wisconsin
Wyoming

**The Kansas Association of Financial Services**
George Barbee, Executive Director
Jayhawk Tower, 700 SW Jackson, Suite 702
Topeka, KS 66603-3740
913/233-0555 Fax: 913/357-6629

Statement to
House Financial Institutions and Insurance Committee
HB 2424

Mr. Chairman and members of the committee my name is George Barbee appearing today on behalf of the Kansas Association of Financial Services in support of House Bill 2424.

Mr. Wright has explained the need for this amendment and we concur with his remarks. Consumer finance loans have changed dramatically during the last decade. Finance companies find that they are making more loans for mobile homes, second mortgages, and larger loans on automobiles. These amounts are exceeding the $50,000 limit for an insurance product that is, in itself, a consumer benefit.

The consumer is not subjected to a detailed application, but rather only very limited underwriting questions to determine insurability. These questions vary from one company to another, but are typically approximately five questions regarding serious health problems.

The regulations governing the issuance of credit life insurance state that anyone under 65 years of age cannot be denied coverage unless they will turn 66 before the loan is scheduled to be paid off. And, the rate is the same for all credit life insureds. An insured of age 60 pays the same rate as an insured of age 30.

Mr. Chairman and members of the committee thank you for this opportunity to speak to House Bill 2424 as we ask you to report this bill favorably.

House F.I.&I.
Attachment 2
2-21-94

STATE OF KANSAS

**CAROL H. SADER**
REPRESENTATIVE, TWENTY-SECOND DISTRICT
JOHNSON COUNTY
**HOME ADDRESS:** 8612 LINDEN DR.
SHAWNEE MISSION, KANSAS 66207
(913) 341-9440

**OFFICE:** ROOM 284-W STATEHOUSE
TOPEKA, KS 66612-1504
(913) 296-7688

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
POLICY CHAIR OF DEMOCRATIC CAUCUS
RANKING MINORITY MEMBER: PUBLIC HEALTH AND WELFARE
ECONOMIC DEVELOPMENT
JOINT COMMITTEE ON HEALTH CARE DECISIONS FOR THE 90'S
NATIONAL COUNCIL OF STATE LEGISLATURES—HEALTH COMMITTEE

# TESTIMONY ON HB2917
# FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE
# February 21, 1994

Mr. Chairman and Members of the Committee:

I appear before you today in support of House Bill2917 designed to prevent health care consumers whose employment has been terminated from losing their health insurance coverage without even knowing about its loss. This bill is intended to accomplish two objectives:
1) clarify the responsibility for notification of termination of COBRA benefits by requiring the insurance company to provide notice to the insured terminated employee of the cancellation of COBRA coverage and a 30-day grace period and 2) to provide a limitation on the premium increase an insurer can charge on a conversion to a direct-pay individual policy of not more than a 150% increase over the COBRA rate.

The problems that this bill is intended to solve were brought to my attention by Mr. Brent Schondelmeyer, the former Editor-in-Chief of the Kansas City Health Care Times, an excellent weekly health care newspaper that ceased publication last July. After a recent very well-attended forum on health care reform which Mr. Schondelmeyer moderated and at which I, and Senators Bond and Praeger served as panelists, Mr. Schondelmeyer told me of his own experience and that of other former employees of the Kansas City Health Care Times in ironically losing their own health insurance coverage without notification and then having to pay a 600% increase for an individual policy with less coverage. Mr. Schondelmeyer is here to explain just how this happened and why these matters need to be addressed and remedied through the statutory changes in HB2917.

Mr. Chairman, with your permission, I will defer to Mr. Schondelmeyer.

Laura F. Dos A
Attachment 3
2-21-94

**House Committee on Financial Institutions and Insurance**
**Feb. 21, 1994 Hearing on House Bill No. 2917**

Testimony submitted by:

Brent Schondelmeyer
501 N. Union
Independence, Mo. 64050
(816) 836-0910

## Summary

State insurance legislation needs to clarify the responsibility for notification of termination of COBRA benefits and provide limitations on premium increases for policies offered under the individual right to convert to direct pay.

## Notification Rights and COBRA Health Insurance Coverage

I am among more than a dozen people who lost their health insurance and did not even know it.

We were young, healthy and had no pre-existing conditions. Moreover, we were ready and willing to pay for health insurance out of our own pockets. Even still, we got temporarily dropped – without our even knowing it – into the growing ranks of the uninsured which now number 37 million.

This is a tale told by a Missouri resident, but equally applicable to any Kansas resident whose health insurance is employer based. Before you dismiss the concern as inconsequential please hear my story.

I am a very knowledgeable about insurance and the health care industry. I have spent the past seven years as a journalist writing, reporting, investigating and editing stories on the health care and insurance industries in metropolitan Kansas City and the bi-state area. I gained that experience as a reporter for the *Kansas City Business Journal* and more recently as the founding editor of the *Kansas City Health Care Times*. [As an aside, I learned about politics while working the for Associated Press covering the 1982 legislative session.]

This is my story. I tell it only briefly.

House FI&I
Attachment 4
2-21-94

I and my other fellow employees lost our health insurance and never ever knew about it until months afterwards. The set of circumstances both surprised me and deeply disappointed me. H.B. 2917 directly addresses those concerns.

The issue is what happens to a person's health insurance when they lose their job – a not unusual occurrence in the American economy. To note, there were 758 business failures in Kansas in 1990 and 1,216 in Missouri, according to the Dun & Bradstreet Corporation.

My employer – *The Kansas City Health Care Times* – closed last July. At that time, I several other employees decided to extend our health care coverage through COBRA coverage which permitted us to extend our health insurance if we individually paid the premium.

COBRA is no viper, rather COBRA – the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) – was adopted by Congress to provide continuation of health care coverage for an employee who is terminated or who loses benefits through reduction of hours. The employee is given 60 days from a "qualifying event" to elect whether they want COBRA coverage.

On Sept. 30, the *Kansas City Health Care Times,* Inc. canceled its group health insurance policy with its health insurer – the company which provided our COBRA coverage. The newspaper, as practical matter, ceased being a business with employees. With no employees, it no longer needed group health coverage. The link to health care coverage, for the former employees, was the group health insurance policy. Cancellation of the group health policy effectively terminated our COBRA coverage. That's the federal law. COBRA coverage ends on "the date on which the employer ceases to provide any group health plan to any employee." [29 U.S.C.A. § 1162 (2)(B)]

However, what was unique to our situation was this fact. Neither the employer nor the insurance company notified us of the cancellation and our loss of health insurance until November – two months later. During that period, we continued to faithfully send checks in to the insurance company which were returned with no explanation. Calls to the insurance company brought reassurances not to worry because we were covered, but offered no explanation for the returned money.

The official explanation – prompted by repeated phone calls – finally came on Nov. 15. That day, I received a letter dated Nov. 4 which categorically stated my health insurance had been canceled Sept. 30. (The letter is attached).

**We lost our health insurance and no one told us or provided us at least 30 days to arrange for alternative coverage.**

The health insurance disclaimed responsibility for informing us of our COBRA termination placing the responsibility on the employer. (A position which is

correct, by all accounts). The employer – a start-up small business – said it was unaware of its responsibility.

Federal COBRA law is very detailed in spelling out employer obligations and responsibilities for letting terminated employees know about rights to elect COBRA coverage. However, both federal and state law is effectively silent or unclear on the question of whose responsibility it is to let employees know they have lost COBRA coverage due to the employer's cancellation of the group health insurance policy.

This is wrong and needs to be addressed legislatively. H.B. 2917 does that by requiring insurance companies to provide the insured individuals notice if the group health policy is canceled by the employer. Not all employers are responsible. Many are small businesses which, once they fail, no longer take interest or responsibility in business affairs. Many entrepreneurs, moreover, lack personnel departments or experience with COBRA or other complicated employee benefit questions.

The same can not be said for insurance companies. The insurance company, in fact, has more regular contact with the individual than the former employer. The insurance company is billing the individual each month for prepayment of next month's COBRA premium. In my view, it makes sense to require the insurance companies to provide notification whenever continued COBRA coverage is lost due to employer cancellation of the group health contract.

It is amazing to me that the insurance company is able to bill you monthly for the premium, but claims inability or no responsibility to inform the insured when COBRA coverage is canceled. As long as health insurance remains employer-linked, responsibility for providing notification of termination of COBRA coverage needs to be firmly fixed in state, if not also federal law.

If you read the COBRA law carefully, the employee has to notify the insurer if they get a divorce or legal separation, a dependent child loses eligibility, the individual becomes entitled to Medicare or death of a spouse. (See attachments)

Is it unreasonable for the insurance company to notify the insured when COBRA coverage – through no fault of the insured – loses coverage due to employer cancellation of the group's health insurance?

Many say the situation is remedied because the state requires the insurance company to offer the individual the option of converting to an individual direct-pay policy. That right to convert to individual direct-pay offers less than one might suspect.

It is hard to exercise the conversion right in a timely manner if the COBRA insured individual is not aware that he or she has lost coverage. But more importantly, that conversion right illustrates the larger issue of inequities evident

when small business and individuals seek health insurance as our health care system currently exists.

My monthly COBRA premium for coverage with a Kansas City area HMO was $102.78. That same insurance company – after the intervention of the Missouri Department of Insurance – finally notified me that I did have a right to convert. A similar conversion right exists in Kansas.

The conversion policy they offered me required me to pre-pay a three-month premium of $2,159, an effective monthly premium of $719 – a 600 percent increase in premium for less coverage and also included a $500 deductible. Needless to say, I have sought and secured coverage with another insurance company which I was able to do because I was in good health.

The purpose of COBRA is help the employee who has lost a job retain health insurance for up to 18 months by having the individual take over payment of the premium. When you lose a job, assuming entire responsibility for health insurance can be expensive particularly if the COBRA policy covers a family. But to be willing to pay COBRA benefits, then lose your insurance without notification and then offered less coverage at a 600 percent increase is rather unconscionable.

Fortunately, no one in the COBRA group had a major medical claim during the two-month period and most have secured coverage through new employment or purchased individual coverage. However, if anyone in the group had had a pre-existing condition securing coverage would have been difficult, most likely, and extremely expensive, for sure.

H.B. 2917 does something that is important – a small matter which should seem eminently reasonable and altogether fair. Notification of loss of COBRA coverage should be an affirmative obligation of insurance companies and not just a courteous and decent business practice.

Until health insurance is portable and not employer-linked, it is important to address issues which I think this example illustrates. The policy issues, as I see them, are:

- Requiring the insurance company and the employer to provide notice of cancellation of COBRA coverage and a 30-day grace period.

  REASON: Everyone deserves to know that the health insurance will be canceled on a date certain and provided an opportunity to secure alternative coverage.

- Placing a limitation on the premium increase an insurer can charge on conversion to a direct-pay individual policy.

REASON: That limitation could be no more than a 150 percent increase over the COBRA rate. Unless a limitation is included, an insurer can offer the right to convert but price it so the individual is unlikely to exercise that right.

Many Americans want health insurance, but are unprepared or unable to pay for it. However, when a recently terminated employee is prepared to pay 100 percent for their own coverage under COBRA it seems reasonable that they be notified when COBRA coverage is canceled and offered a reasonable, affordable opportunity to convert to direct-pay individual coverage.

We should be encouraging individuals to provide for and pay for health insurance, not making it difficult and onerous to do so. H.B. 2917 is a modest step, easily accomplished.

I wish to thank Rep. Carol Sader for introducing this legislation and inviting me to share these concerns with you. Thank for your taking the time to consider these issues.

N69158-1-493584504-160-SCHC

the Principal Financial Group

Grand Island
Group Insurance Center

Principal Mutual
Life Insurance Company

November 4, 1993

BRENT L SCHONDELMEYER
501 N UNION
INDEPENDENCE MO 64050

Acct No: N69158-1-493584504
Cobra Terminations

706
G-028

Your group health coverage has been continued as allowed by COBRA under N69158-1/Kansas City Healthcare plan. The group plan has terminated with us effective September 30, 1993. Since your continued coverage is through Kansas City Healthcare plan, your group health coverage with us will also terminate as of this date.

COBRA provides that continued coverage for qualified persons terminates the date that an employer ceases to maintain any group health plans. If Kansas City Healthcare has replaced this plan with a new carrier, you may be eligible to complete your continuation period under the new policy.

COBRA also provides that if an employer maintains separate group health plans, if any one separate group health plan is eliminated, the qualified persons under that plan must be permitted to elect coverage under any of the remaining plans maintained by the employer for similarly situated active employees. You may wish to contact Kansas City Healthcare regarding your continuation options.

You have a credit of $102.77 remaining after the cancellation date of your coverage. We will mail the refund after your payment has cleared the bank.

Please submit any claims incurred through the termination date. If you have any questions, please contact me.

Sincerely

Lisa Nutter
Pooled Group Administration
1-800-247-6699 Ext.84324

CC ATTN TIFFANY KANAK
KANSAS CITY HEALTHCARE
12401 E 43RD ST NO 160
INDEPENDENCE MO 64055

thePrincipal Financial Group

Principal Mutual Life
Insurance Company
Des Moines, Iowa 50392-0001

August 13, 1993

BRENT L SCHONDELMEYER
501 N UNION
INDEPENDENCE MO 64050

RE: Account No. N69158-1-493584504

Thank you for your application for continuation of Group Health coverage due to the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Your continued coverage is effective August 1, 1993.

Enclosed is your first statement. Also enclosed is a sample COBRA continuation statement with instructions on reporting any changes in status for yourself and/or any of your dependents.

Your account will be billed on a monthly basis. Your statements will be mailed to you on the 25th of each month. Payment is then due by the first of the month with a 31 day grace period. If payment is not received by the end of the grace period, your coverage will terminate effective as of the last day for which premium has been received.

We have included claim forms and claim office envelopes for your use. A supply requisition form is enclosed, in the event you need to order more claim forms or envelopes. You will find instructions on the claim forms for filing a claim.

Please inform us immediately if you or any of your dependents are no longer eligible for this continued coverage as outlined in your application.

Be sure to use your complete account number indicated above on all correspondence, claims, and checks to ensure proper handling. If you have any questions, please contact me.

Sincerely

KATHY KUSZAK
GRAND ISLAND ADMIN - PG
Phone 308-389-4331

cc: KANSAS CITY HEALTHCARE
ATTN DIAN SEALS
12401 E 43RD ST NO 160
INDEPENDENCE MO 64055

4-7

the Principal Financial Group

The Principal Financial Group
Des Moines, IA 50392-0001

**Principal Mutual Life Insurance Company**

**PREMIUM STATEMENT**

This statement in no wa s the contract or waives any payment

0000000001 000000069158 000014935845046B 9

**THIS IS YOUR COPY. PLEASE KEEP FOR YOUR RECORDS.**

Make check payable and mail to:

BRENT L SCHONDELMEYER
501 N UNION
INDEPENDENCE MO 64050

PRINCIPAL MUTUAL
P O BOX 9221
DES MOINES IA 50306

**Account Number** N69158-1-493584504 **Lb. No.** 69158 00001 493584504 68

**Please Pay Balance Due**
$ .01

BILLING PERIOD 08/01/93 - 08/31/93

DUE DATE: 08/01/93 STMT DATE: 08/13/93 PREMIUM MUST BE RECEIVED WITHIN 31 DAYS OF 08/01/93

**********
PLEASE NOTIFY US IMMEDIATELY IF YOU OR ANY DEPENDENT COVERED, HAVE OBTAINED OTHER COVERAGE FROM ANOTHER GROUP INSURANCE CARRIER OR MEDICARE.
**********

**********
YOUR FIRST STATEMENT INCLUDES CHARGES FROM THE EFFECTIVE DATE OF YOUR CONTINUATION. THE BILL MONTH COLUMN REFLECTS THE MONTHS YOU ARE BEING BILLED FOR ON THIS STATEMENT.
**********

PLEASE REVIEW THE MESSAGES ABOVE. THEY CONTAIN INFORMATION RELATED TO YOUR PREMIUM PAYMENTS AND THE ADMINISTRATION OF YOUR PLAN. IF YOU HAVE QUESTIONS REGARDING ANY OF THESE MESSAGES, PLEASE CONTACT US AT THE NUMBER LISTED BELOW.

PLEASE REFER TO YOUR ADMINISTRATION GUIDE FOR CHANGES THAT CAN BE MADE BY PHONE. REPORT NEW ENROLLMENTS, TERMINATIONS AND CHANGES IN CLASSIFICATION OR DEPENDENT STATUS. SEE THE FOLLOWING PAGE FOR REPORTING CHANGES.

FOR ASSISTANCE, PLEASE CALL: 308-389-4331.

4-8

The Principal Financial Group
Des Moines, IA 50392-0001

**Principal Mutual Life Insurance Company**

**REPORTING FORM**

This statement in no wa ; the contract or waives any o payment

0000000001 000000069158 000014935845046 8 9

**RETURN THIS COPY WITH YOUR PREMIUM PAYMENT.**

Make check payable and mail to:

BRENT L SCHONDELMEYER
501 N UNION
INDEPENDENCE MO 64050

PRINCIPAL MUTUAL
P O BOX 9221
DES MOINES IA 50306

**Account Number** N69158-1-493584504 **Lb. No.** 69158 00001 493584504 68

**Please Pay Balance Due**
$ .01

BILLING PERIOD 08/01/93 - 08/31/93

DUE DATE: 08/01/93 STMT DATE: 08/13/93 PREMIUM MUST BE RECEIVED WITHIN 31 DAYS OF 08/01/93

PLEASE REFER TO YOUR ADMINISTRATION GUIDE FOR REPORTING INSTRUCTIONS. IT IS NOT NECESSARY TO REPORT A CHANGE ALREADY MADE BY PHONE. THIS INCLUDES TERMINATIONS, LAY-OFFS, LEAVES OF ABSENCE, RETIREMENTS, CONTINUATIONS, SALARY CHANGES, JOB CLASS CHANGES, DEP STATUS CHANGES - MARRIAGE/DIVORCE, AND COMPANY ADDRESS/PHONE CHANGES.

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TO ASSURE YOUR PAYMENT IS PROMPTLY AND ACCURATELY APPLIED, PLEASE DETACH THE UPPER PORTION OF THIS PAGE TO RETURN WITH YOUR PAYMENT. RETURN THE LOWER PORTION ONLY IF YOU HAVE CHANGES TO REPORT.

REPORT NEW ENROLLMENTS, TERMINATIONS AND CHANGES IN CLASSIFICATION OR DEPENDENT STATUS.

FOR ASSISTANCE, PLEASE CALL: 308-389-4331.

4-9



F407GP-2

# MEMORANDUM

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

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

DATE: February 21, 1994

RE: H.B. 2917

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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. 2917.

H.B. 2917 proposes to amend the uniform provisions dealing with accident and health insurance as they relate to continuation and conversion privileges.

The first amendment is found on page 5 starting on line 21 through 23. This is instituting a notice requirement in regard to converted policies. Please be advised that my client has no opposition to inserting a notice requirement in the law. As a practical matter, most carriers already provide for notice, and as such we do not believe including it in the mandatory provisions would be inappropriate. A corresponding amendment is found on page 11 starting on line 40 through 43 and continuing on page 12 starting on line 1 through 2. Again, we have no problem with instituting the 30-day notice requirement. However, we would note that we are uncertain as to whether you can

House FI&I
Attachment 5
2-21-94

include this requirement for those policies issued under 29 U.S.C. 1161, et seq., commonly referred to as COBRA benefits. However, with respect to our products, we again have no problem with the notice requirement.

The final amendment that the bill proposes is again found on page 5 starting on line 40 and 41. Current law states that the individual who has converted his or her coverage from a group policy to an individual policy can be charged rates that are self-sustaining and are not unreasonable in relation to the coverage provided based upon conversion morbidity and reasonable assumptions for expected medical care costs. This language has been deleted and new language has been inserted that makes a flat premium cap to not exceed 150% of the premium rate of the group policy.

First, we believe it is important to realize that the policy being converted is one which an individual had under a group coverage into an individual policy. Attempting to compare rates between a group policy and an individual policy and thereby instituting a cap is in our minds in appropriate and in many cases unreasonable. Group coverages and their respective rates are computed on a substantially different basis than individual rates. Thus, the commonality between the two is remote, and as such putting an artificial cap on the rate would not be appropriate.

Although the instances of an individual rate being in excess of 150% of the premium rate of the group policy may be remote, we would submit that placing this premium cap in the uniform provisions would create an artificial rating system that would not accurately reflect the true components which generate the rate. Thus, we would

respectfully request that the new language found on page five on lines 40 and 41 be deleted and current law be reinstituted.

We appreciate the opportunity to present this testimony to the Committee, and if you have any questions or comments we would be happy to respond.

Respectfully submitted,

William W. Sneed

**40-1126.** Reports by insurers of health care providers, attorneys and persons engaged in technical professions; certain claims, actions and charges; health care provider defined. (a) Every insurer providing professional liability insurance to a health care provider, a person engaged in any technical profession, as defined by K.S.A. 74-7003 and amendments thereto, any attorney admitted to practice before the supreme court of this state or any certified public accountant licensed to practice by the board of accountancy shall report to the commissioner of insurance: (1) Any claim or action for damages for personal injuries or loss claimed to have been caused by error, omission, or negligence in performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in: (i) A final judgment in any amount; (ii) a settlement in any amount; (iii) a final disposition not resulting in payment on behalf of the insured; and (2) the amount of premiums charged for professional liability insurance of the types described in clause (1) of subsection (a) for the past calendar year, which shall be reported as separate items so that each such type may be distinguished from premiums charged for other types of insurance.

(b) Reports of the information required by clause (2) of subsection (a) shall be filed with the commissioner of insurance annually on or before March 1; reports of the information required by clause (1) of subsection (a) shall be filed with the commissioner of insurance no later than 30 days following the results of a claim set out in items (i), (ii) or (iii) of clause (1) of subsection (a).

(c) As used in K.S.A. 40-1126 to 40-1128, inclusive, and amendments thereto, the term "health care provider" means a person licensed to practice the healing arts or engaged in a postgraduate training program approved by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts, a licensed dentist, a licensed professional nurse, a licensed practical nurse, a licensed optometrist, a licensed pharmacist, a licensed medical care facility, a health maintenance organization issued a certificate of authority by the commissioner of insurance, a licensed podiatrist, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a registered physical therapist or a community mental health center or mental health clinic licensed by the secretary of social and rehabilitation services.

**History:** L. 1975, ch. 241, § 1; L. 1976, ch. 216, § 1; L. 1977, ch. 160, § 1; L. 1978, ch. 178, § 1; L. 1986, ch. 231, § 3; L. 1988, ch. 246, § 11; July 1.

**Cross References to Related Sections:**
Kansas healing arts act, see ch. 65, art. 28.

**Law Review and Bar Journal References:**
"Report on Health Care Provider Insurance Availability Act," Fletcher Bell, 82 J.K.M.S. 308, 316 (1981).

**CASE ANNOTATIONS**

1. Referred to in upholding constitutionality of malpractice insurance act (40-3401 et seq.). State, ex rel. Schneider v. Liggett, 223 K. 610, 611, 576 P.2d 221.

**40-1127.** Same; contents; copies of report provided to certain agencies of the state. The reports required by clause (1) of subsection (a) of K.S.A. 40-1126 shall contain: (a) The name, address, and specialty coverage of the insured; (b) the insured's policy number; (c) date of occurrence which created the claim; (d) date of suit if filed; (e) date and amount of judgment or settlement, if any; and the parties involved in the distributions of such judgment or settlement and the amount received by any such party; (f) date and reason for final disposition if no judgment or settlement; (g) a summary of the occurrence which created the claim; and (h) such other information as the commissioner may require. The commissioner of insurance shall provide a copy of each such report relating to health care providers to the board which licenses or registers such health care provider or to the secretary of health and environment in the case of a licensed medical care facility.

**History:** L. 1975, ch. 241, § 2; L. 1976, ch. 216, § 2; L. 1977, ch. 160, § 2; L. 1978, ch. 178, § 2; July 1.

**Law Review and Bar Journal References:**
"Report on Health Care Provider Insurance Availability Act," Fletcher Bell, 82 J.K.M.S. 308, 316 (1981).

**40-1128.** Same; disclosure. The commissioner of insurance shall make such reports available to the public in a manner which will not reveal the names of any person or facility involved.

**History:** L. 1975, ch. 241, § 3; L. 1976, ch. 216, § 3; April 20.

**40-1129.** Same; no liability. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer reporting hereunder or its agents or employees, or the commissioner of insurance or the commissioner's employees, for any action taken by them pursuant to this act.

**History:** L. 1975, ch. 241, § 4; July 1.

House F&L
Attachment 6
2-21-94

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**STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL FOR THE AMERICAN INSURANCE ASSOCIATION,**

**PRESENTED TO THE KANSAS HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE REGARDING 1994 HOUSE BILL 3041, FEBRUARY 21, 1994.**

Mr. Chairman and Members of the Committee:

I am Brad Smoot, Legislative Counsel for the American Insurance Association (AIA), a trade association representing more than 200 companies providing a variety of insurance products to Kansans and across the nation.

Thank you for introducing H 3041, as requested by the American Insurance Association. The bill would simply repeal four related statutes, K.S.A. 40-1126 through 40-1129. These provisions were adopted in 1975 as part of the tort reform legislation and concern reporting of claims and premium data for professional liability insurance.

Claims data is reported monthly from closed claims and premium data is reported annually on forms prepared by the Insurance Department. Several professions are covered by the act, including physicians, attorneys, hospitals, dentists, optometrists, engineers, architects, etc. The statute calls for the data to be reported annually to the regulatory or licensing board of each professional group.

As you can imagine, the cost of reviewing claims and filing the necessary forms for all such groups by all liability carriers in Kansas is substantial. The cost may vary from company to company depending on the amount of business it writes in Kansas, the number of claims it has to report and whether the company is automated or must prepare the reports by hand. Sample responses from AIA member companies is that the average annual cost to prepare the reports is $3000. This cost, of course, is passed on the our insureds as part of premium.

House F.I.&I.
Attachment 7
2-21-94

Other than the annual Report on the Health Care Provider Insurance Availability Act prepared by the Insurance Department and provided to the Healing Arts Board, we are unaware of any compilation, analysis or use for this data. While we have no concern about the disclosure of the data collected and are pleased to continue the current practice if it has real value, we urge the Committee to evaluate to utility of this reporting requirement in light of its cost to premium payers.

Thank you for your consideration of our views and I would be pleased to respond to questions from the Committee.

r the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription agreement but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance; (6) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall not be less than 10 days; and (7) if applicable, a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber may be entitled to in such kinds of hospitals. The subscriber shall be entitled to benefits in any nonparticipating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals. ~~The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers.~~

(c) In every such subscription agreement made, issued or delivered in this state: (1) All printed portions shall be plainly printed; (2) the exceptions of the subscription agreement shall appear with the same prominence as the benefits to which they apply; (3) if the subscription agreement contains any provisions purporting to make any portion of the articles of incorporation or bylaws of the corporation a part of the subscription agreement, such portion shall be set forth in full; and (4) there shall be a brief description of the subscription agreement on the first page and on its filing back.

(d) Any such corporations may issue a group or blanket subscription agreement, provided the group of persons insured conforms to the requirements of law applicable to other companies writing group or blanket sickness and accident insurance policies and provided such subscription agreement and the individual certificates issued to members of the group shall comply in substance with this section. Any such subscription agreement may provide for the adjustment of the premiums based upon the experience at the end of the first year or of any subsequent year of insurance, and such readjustment may be made retroactive in the form of a rate credit or a cash refund.

(e) (1) Any group subscription agreement issued pursuant to subsection (d) shall provide that an employee or member or such employee's or member's covered dependents whose insurance under group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with

Reinstate:

The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers.

Add:

except that benefit checks paid directly to the insured must include the name of the non-contracting health care provider as well.

Attachment 8
2-21-94