Approved: April 1, 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 March 16, 1994 in Room 527-S of the Capitol.

All members were present except: Representative Susan Wagle
Representative George Teagarden

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

Conferees appearing before the committee: Brad Smoot, Hartford Steam Boiler and Inspection Company
Dick Brock, Insurance Department
Representative Al Lane
Joe Speyer, Speyer Realty Company
Jean Duncan, Real Estate Commission

Others attending: See attached list

HEARING ON SB 568: Repeal of requirements of stock value for certain companies

Brad Smoot, representing the Hartford Steam Boiler Inspection and Insurance Company, explained the unique law of Kansas regarding $1 par value requirements for stock (Attachment 1). This statute has had the effect of substituting a $2.5 million insurer (at the time) for a $700 million company which seems contrary to the apparent consumer interests. Problems have developed with the Industrial Risk Insurers as Hartford has participated in IRI at a rate of .484% or $21,780 of the $4.5 million direct written premium in Kansas. Hartford must either withdraw from the IRI or amend its bylaws to require a $1 par value. Neither appears to be in the best interest of Kansas customers or shareholders. They are hereby requesting the repeal of the current statute K.S.A. 40-209a.

HEARING ON SB 569: Risk-based capital requirements

This bill would require domestic life insurance companies, and foreign companies upon request, to submit with their annual statement to the Insurance Commissioner, a report of their risk-based capital levels at the end of the calendar year. Bill would authorize increasingly serious regulatory action against a deficient company.

Dick Brock, Insurance Department, stated that the bill would require that insurers maintain an amount of capital and/or surplus that is commensurate with the perceived riskiness of their respective assets, liabilities, and off-balance sheet activities (Attachment 2). The four major categories of risks to be measured are those associated with: a) the insurer's assets, e.g. investment portfolio; b) the type of insurance the company writes, e.g. predominantly traditional life insurance products versus interest sensitive contracts; c) an insurer's profitability because of interest rate considerations, e.g. single premium deferred annuity products where the guaranteed interest rate is designed to compete with non-insurance investment products; and d) other variable aspects of an insurer's operations, e.g. underwriting philosophy, marketing strategies, management goals, etc. Each Kansas domestic life insurer would be required to calculate its Risk Based Capital (RBC) and provide the Department with more specific authority to take regulatory action against a company in deteriorating financial condition. It would also require insurers to maintain a minimum level of capital specific to the risk inherent in each company's operations.

HEARING ON SB 680: Exemption from continuing education requirements for real estate brokers and salespersons licensed 10 or more years and 80 or more years of age

This bill would allow the Real Estate Commission to waive the continuing education requirement for those licensees who are 80 years of age, or older, and who have been licensed for ten years.

Representative Al Lane introduced Mr. Joseph Speyer of Speyer Realty Company who operates realty companies in both Missouri and Kansas.

Joe Speyer stated he had been in the real estate business for 45 years and has taken continuing education courses for license renewal every two years as required as well as reading bulletins, books, magazines and whatever other materials are available for his profession. The courses are now repetitive for him and others with his experience. Mr. Speyer recommends that Kansas adopt a policy much the same as Missouri has which would exempt 80 year old licensees from taking continuing education courses if the Commission on Real Estate agrees with the waiver (Attachment 3). This waiver would not have to be refiled with each license renewal but would be ongoing.

Jean Duncan, Director of the Kansas Real Estate Commission, stated their objection to this proposal (Attachment 4). Their belief is that all licensees need current knowledge to protect consumers in real estate transactions. It is not good policy to open the door to waivers thereby inviting others to propose waivers for other groups or reasons.

ACTION ON SB 612: Insurance plans subject to group health and accident requirements

The bill expands portability of benefits by requiring that waiting periods for coverage be waived not only for movement from one group policy to another, but also for movement from an individual policy, a self-insured plan such as ERISA, a multiple employer welfare association , or a municipal funded pool. Credit for waiting periods served under one policy would be portable for a period of 31 days from the date of termination of coverage under one type of policy to the beginning of coverage under a new policy.

Bill would also expand the size of a "small group" plan for no more than 25 employees to no more than 50 employees, so that guaranteed access provisions and rating restrictions are applicable to small employer groups with 50 or fewer employees, as opposed to the current 25 or fewer employees.

An informative letter from William Sneed, HIAA, was distributed to the Committee (Attachment 5).

An amendment changing the waiting period from one year to 90 days on group policies was presented. Representative Barbara Allen moved for the acceptance of the amendment. Motion was seconded by Representative Neufeld. Motion carried. (Attachment 6)

The 90 day waiting period would cover all group policies and would go into effect on the anniversary date of the contract.

Representative Neufeld moved to add a new section in the bill which would restrict the sale of stop/loss insurance to small employers thus making it difficult to opt out of the community pool through the mechanism of self insurance with stop/loss coverage. The motion was seconded by Representative Cornfield. Motion carried.

Chip Wheelen of the Kansas Psychiatric Society presented an amendment which would include coverage for diagnosis and medically necessary treatment of mental illness in any SEHC plan offered or delivered in this state (Attachment 7).

Representative Sebelius moved to accept the KPS amendment which would add a new mandate on small group policies relative to psychiatric care. The motion was seconded by Representative Bruns. Motion carried.

Representative Sebelius moved that a definition for exactly what psychiatric care is included in the bill be amended into it. The motion was seconded by Representative Helgerson. Motion carried.

There was a review of mental health mandates and a discussion if a fiscal note would be required. Distinction needs to be made between mental and medical help.

Representative Bruns moved to pass the bill out favorably as amended. Motion was seconded by Representative Gilbert. Motion carried.

ACTION ON SB 566: Kansas uninsurable health insurance plan; pre-existing conditions

Concern was voiced that some people might wait until symptoms of illness appear before joining an insurance group unless the 90 day waiting period was part of the plan. This may prevent major abuse.

Representative Allen moved to pass the bill out favorably. Motion was seconded by Representative Neufeld. Motion carried.

ACTION ON SB 563: Valuation for reserve requirements for life and accident and sickness insurance

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

ACTION ON SB 487: Regulation of utilization review organizations

Representative King presented an amendment for a new definition of "health care provider;" a new subsection of entities not required to obtain certificate to conduct utilization review activities; and to increase the size of the advisory committee from 11 to 13 members and to increase the number to 7 for health care providers. Motion was seconded by Representative Bruns. Motion carried. (Attachment 8)

Representative Correll moved that the bill be passed out as amended. Motion seconded by Representative Cox. Motion carried.

ACTION ON SB 640 (HB 2823): Insurance reimbursement for certain persons performing mammography and prostate-specific antigen testing

Representative Helgerson moved to reinsert requirement that testing is to be done according to American Cancer Society guidelines and that the bill become effective upon publication in the Register. Motion was seconded by Representative Dawson. Motion carried.

Those facilities performing mammograms and not following the guidelines would not be covered for insurance purposes. The bill will not include prostate-specific antigen testing as this will require a study and ultimate mandate.

Representative Correll moved that the bill be passed out favorably as amended. Motion was seconded by Representative Cox. Motion carried.

Representative Cox moved that the minutes of March 8 be approved. Motion was seconded by Representative Correll. Motion carried.

The meeting adjourned at 5:25 p.m. The next meeting is scheduled for March 17, 1994.

GUEST LIST

COMMITTEE: Fed DATE: 3-16-94

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIC
Joseph Speyer	300 WESTPORT RD. K.C., MO.	SPEYER REALTY CO
Robb Hardman	2505 winterbrook LO Lawr KS	Rep. Allen's intern
Danielle Noe	Topeka	State Farm
Jean Duncan	Topeka	KREC
KAREN FRANCE	"	KAR
Rick Brock	"	Ins Dept
Roger Fraude	"	Ks Gov. Consulting
Chip Wheelen	Topeka	KS Medical Soc.
David Ross	Topeka	Ks. Assn. Life Underwriters
GARY Robbins	Topeka	Ks Optometric Assn
Dave Wakworth	Topeka	Division of the Budget

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STATEMENT OF BRAD SMOOT, LEGISLATIVE COUNSEL FOR THE HARTFORD STEAM BOILER INSPECTION & INSURANCE COMPANY,

PRESENTED TO THE KANSAS HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE REGARDING 1994 SENATE BILL 568, MARCH 16, 1994.

Chairman Bryant and Members of the Committee:

I am Brad Smoot representing The Hartford Steam Boiler Inspection and Insurance Company of Connecticut (HSBC), a wholly-owned subsidiary of The Hartford Steam Boiler Inspection & Insurance Company (HSB), an engineering and property insurance company with 1992 revenues of $682.1 million. The Kansas Insurance Department has licensed HSBC to do business in Kansas as a property and casualty insurer. We appear today in support of 1994 Senate Bill 568 which would repeal K.S.A. 40-209a, copy is attached.

Approximately seven years ago, the parent company's shareholders eliminated the par value of HSB's stock. The reason HSB eliminated its par value was to permit it to declare stock splits without having to convene shareholders to approve a charter amendment each time. For references to the Kansas Corporation Code permitting such actions by corporations, see K.S.A. 17-6403 and 17-6602.

As a result of the elimination of par value stock, we were notified by the Kansas Insurance Department of the requirements of K.S.A. 40-209a. The par value requirements of Kansas law are utterly unique in the fifty states. (California requires a par value although no minimum amount is specified.) HSB created HSBC solely as a result of the Kansas law and structured it to meet the $1 par value stock requirements of the above statute. As we indicated to the Department in 1989, this unique Kansas law had the effect of substituting a $2.5 million insurer (at the time) for a $700 million

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company, which seems contrary to the apparent consumer interests of K.S.A. 40-209a and other Kansas insurance laws.

In December of 1992, we notified the Kansas Insurance Department of the problems we were experiencing with the Industrial Risk Insurers (IRI), a joint underwriting association authorized under K.S.A. 40-273. In 1992, HSB participated in IRI at a rate of .484% or $21,780 of the $4.5 million direct written premium in Kansas covering 130 insureds including well-known companies such as Boeing and General Motors. Since IRI does not permit insurers to participate on a state by state basis, HSB must either withdraw from the IRI or amend its bylaws to require a $1 par value. Neither prospect appears to be in the best interests of our Kansas customers or our shareholders.

In light of the extensive protections provided Kansas insureds by K.S.A. 40-901, governing the capital and surplus requirements, and applicable holding company laws, there is a real question whether K.S.A. 40-209a truly extends any additional protections for Kansas insureds. Consequently, we would urge the Committee recommend SB 568 favorably for passage.

I would be pleased to respond to questions from the Committee.

40-209a. Foreign stock companies; par value of shares required. No stock insurance company now or hereafter to be organized under the laws of the United States or any state thereof shall be authorized to do business in this state unless the shares of capital stock of such company shall have a par value of at least one dollar ($1) per share, which value shall be fixed by the articles of incorporation.

History: L. 1931, ch. 210, § 1; L. 1970, ch. 174, § 1; March 11.

Testimony on
Senate Bill No. 569
by
Dick Brock
Kansas Insurance Department

Historically, insurance companies have been subject to what we call minimum financial requirements as a fundamental prerequisite to their ability to transact business in this state. For example, as of May 1 of this year, a stock life insurance company must have paid-in capital stock of at least $600,000 and a surplus of at least $600,000 in order to qualify for a Kansas Certificate of Authority. For a mutual life insurance company an equivalent requirement applies but, because a mutual does not have capital stock the $1.2 million applies to surplus only. Obviously, $1.2 million is not sufficient to cover an insurance company's obligations if it writes any business at all but if proper reserves are maintained, required deposits are made and the company's financial condition is appropriately monitored, it used to be theoretically presumed that the company's certificate would be revoked before the minimum capital and surplus was greatly impaired. If so, the company's minimum capital and/or surplus would be necessary only to accommodate minor miscalculations or contingencies because the insurer would only be statutorily insolvent. That is it would not have sufficient capital and/or surplus to continue in business but it would not be insolvent in the strict sense of having liabilities in excess of the company's resources.

When life insurers began to develop products that were designed to compete with investment-type securities, accident and sickness insurance claim costs became unpredictable, legal liability emerged as a frequent costly and volatile exposure, and as insurance attempted to accommodate increasingly complex risks, the financial stability of insurance companies became much more difficult to gauge. As a result, insurance regulators began to require more frequent financial reporting and development of more sophisticated tools such as the NAIC's automated early warning system to detect potential problem companies earlier. These efforts were and are productive but their success revealed another problem. Specifically, much of the advantage of

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detecting problem companies earlier was lost because the law until the early 70's for Kansas and much more recent for some states did not permit the regulator to take action until the company's capital and/or surplus was actually below the minimum statutory level.

In 1972 Kansas addressed this problem by enactment of what we call the "hazardous condition law". Under this law, the Commissioner is authorized to deem that a company is in a hazardous financial condition notwithstanding the fact that it may still be in compliance with whatever minimum financial requirements apply. Once deemed to be in a hazardous financial condition, the Commissioner can then order the company to take one or more actions such as the cessation of writing new business; placing a specified amount of securities on deposit for the protection of policyholders; require changes in the company's reinsurance program and so forth to either rectify the situation or protect policyholder interests while the insurer attempts to gain financial strength.

Senate Bill No. 569 is another step in this progression. In essence, this bill will require that insurers maintain an amount of capital and/or surplus that is commensurate with the perceived riskiness of their respective assets, liabilities and off-balance sheet activities. More specifically, the 4 major categories of risks to be measured are those associated with: (a) the insurer's assets, e.g. investment portfolio; (b) the type of insurance the company writes, e.g. predominantly traditional life insurance products versus interest sensitive contracts; (c) an insurer's profitability because of interest rate considerations, e.g. single premium deferred annuity products where the guaranteed interest rate is designed to compete with non-insurance investment products; and (d) other variable aspects of an insurer's operations, e.g. underwriting philosophy, marketing strategies, management goals, and so forth.

This bill would require each Kansas domestic life insurer to calculate its Risk Based Capital (RBC) and, in turn, provide the Department with more specific authority to take regulatory action against a company in deteriorating financial condition. It would also require insurers to

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maintain a minimum level of capital specific to the risk inherent in each company's operations.

When a company is found to be inadequately capitalized, the bill calls for increasingly serious action by the Commissioner, commensurate with various levels of inadequacy of actual capital compared to risk based capital calculations.

Foreign insurers would also be required to file RBC reports with the Department, when requested by the Commissioner. If a foreign insurer's RBC is inadequate, the Commissioner would have authority to take specific regulatory action if the state of domicile does not react to the deficiency.

As previously indicated, utilization of risk based capital requirements is expected to be a more effective alternative to current fixed level minimum capital requirements in that RBC will be unique to each company and will vary as operating conditions change over time.

The RBC is calculated by applying factors to selected annual statement asset, liability, and reserve items. These factors are established by the National Association of Insurance Commissioners and represent the outcome of extensive technical analysis regarding the amount of capital needed to cover the identified risks. The calculation can be complex, with varying factors for different classes of assets and liabilities and different lines of business. Some factors may also vary by the concentration of the company's exposure in an area.

Based on the relationship the formula produced RBC bears to the company's actual capital and or surplus, four levels of progressively serious regulatory action are provided by the bill. Again, these actions are triggered by ratios of a company's adjusted capital to RBC calculations.

A Company Action Level Event occurs when capital to RBC ratios are: (a) 125% to 100% of RBC and trending negatively or (b) 100% to 75% of RBC. In this event, the company must file an RBC plan subject to regulatory review and approval. Within the RBC plan the company must:

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. identify conditions within the insurer that contribute to the deficient RBC level;

. propose actions the insurer intends to take to eliminate the RBC deficiency;

. provide a five year projection of income, capital, surplus, and new and renewal business;

. identify key assumptions and the sensitivity of projections to the assumptions; and

. identify business quality and problems, including assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance.

A Regulatory Action Level Event occurs when capital to RBC ratios are between 50% and 75% of RBC. The event also occurs when a company fails to file an RBC report by the filing date without satisfactory explanation to the Commissioner or fails to timely submit a required RBC plan; when the Commissioner determines that an RBC plan is unsatisfactory; or when an insurer fails to adhere to its RBC plan in a way that has a substantial adverse effect.

When a Regulatory Action Level Event occurs, the insurer must submit a satisfactory RBC plan as previously described. The Commissioner will also examine the insurer and issue a Corrective Order specifying the required remedial actions.

An Authorized Control Level Event is triggered by a capital to RBC ratio of between 35% and 50% of RBC or the company's failure to respond to a Corrective Order. For an Authorized Control Level Event, the Commissioner will either take the action described above for a Regulatory Action Level Event or, if considered to be in the best interest of policyholders, creditors, and the public, the Commissioner can initiate receivership

proceedings. If the Commissioner determines receivership is necessary, the Authorized Control Level Event is sufficient grounds for such action.

A Mandatory Control Level Event occurs when the capital to RBC level falls below 35% of RBC. When this occurs, the Commissioner is required to take the actions necessary to place the insurer in receivership. If the Commissioner reasonably expects that the Mandatory Control Level Event can be eliminated within 90 days, action may be delayed for no more than 90 days after the event.

Any of these regulatory steps is preceded by appropriate due process. Specifically, an insurer has a right to an administrative hearing following notification that:

. the Commissioner has adjusted an insurer's RBC report to correct an inaccuracy;

. the insurer's RBC plan is unsatisfactory, thus constituting a Regulatory Action Level Event;

. the insurer has failed to follow its RBC plan causing a substantial adverse effect on the company's ability to eliminate the company action level event; or

. the Commissioner is issuing a Corrective Order.

All RBC reports, RBC plans, work papers, and Corrective Orders must be kept confidential by the Commissioner except for purposes of enforcing actions taken under Kansas insurance laws. Comparison of an insurer's total adjusted capital to the RBC level will be used exclusively as a regulatory tool to indicate the need for possible corrective action. It is not intended as a means to rank insurers generally and, therefore, public disclosure, in any manner or form, of information regarding the RBC level or any component derived in the calculation of RBC levels of any insurer is prohibited. Insurers are likewise cautioned that this restriction forbids

use of RBC ratios or RBC levels for advertising or any other public announcements.

Attached to my testimony is a chart I lifted from a newsletter distributed by the Illinois Insurance Department which hopefully more clearly portrays the various triggers and regulatory actions Senate Bill No. 569 authorizes.

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Risk Based Capital
Life, Accident and Health

% RBC		
125 and trending negatively		
100	Company Action	File RBC Plan and projections. Review and approval by Regulators.
75	Company Action	File RBC Plan and projections. Review and approval by Regulators.
50	Regulatory Action	Same as above, but Regulator issues Corrective Order.
35	Authorized Control	Same as above, but Regulator has option to initiate Receivership.
	Mandatory Control	Receivership (or 90 day waiting period if Regulator believes problems can be solved in that time.)

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February 10, 1994

Joseph Speyer
Speyer Realty Co.
4050 Broadway
Kansas City, MO 64111

Dear Mr. Speyer:

Attached is a copy of a page from the current Missouri Real Estate Commission Statutes & Regulations book dated December, 1993.

This shows that under certain conditions the commission may waive all or part of the Continuing Education requirements. Item #E states waiver may be granted to a licensee who is at least 80 years of age. To the best of my recollection this ruling has been in effect for 10 years or more. I called the Missouri Real Estate Commission offices in Jefferson City and they could not give me an exact date but advised me that it had been in effect for a long time.

I hope this gives you the information you need.

Please call if I can be of further assistance to you.

Sincerely,

Reta M. Sullivan

Reta M. Sullivan
Education Administrator

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(4) This rule shall not be deemed to limit the commission's authority to file a complaint with the Administrative Hearing Commission charging a licensee with any actionable conduct or violation, whether any complaint exceeds the scope of the acts charged in a preliminary complaint filed with the commission and whether any complaint has been filed with the commission.

(5) The commission interprets this rule, which is required by law, to exist for the benefit of those members of the public who submit complaints to the commission. This rule is not deemed to protect, or inure to the benefit of, those licensees, or other persons against whom the commission has instituted or may institute administrative or judicial proceedings concerning possible violations of the provisions of chapter 339, RSMo.

250-9.020 Investigation

(1) Upon receipt of a complaint in proper form, the commission shall investigate the actions of the licensee against whom the complaint is made. In conducting an investigation, the commission, in its discretion, may request the licensee under investigation to answer the charges made against him/her in writing and to produce relevant documentary evidence and may request him/her to appear before it. A copy of any written answer of the licensee shall be furnished to the complainant.

250-9.030 Dismissal of Complaint

(1) If the investigation reveals that the complaint does not involve the violation of the license law or these rules of the commission, the complaint will be dismissed by the commission and the parties involved will be so advised.

(2) Withdrawal of a valid, legitimate complaint against a licensee as the result of restitution of money or property to the complainant, or other corrective action by the licensee, shall not be grounds for dismissal of the complaint by the commission except at its discretion.

250-9.040 Violations

(1) If the investigation discloses a probability that the acts of the licensee may be those to justify disciplinary action against him/her, the matter will be presented to the Administrative Hearing Commission for determination.

250-9.050 Action by the Commission

(1) Upon final ruling by the Administrative Hearing Commission that the acts of a licensee constitute a violation of the license law or these rules, the commission shall proceed to revoke or suspend the license of the offending licensee or take other authorized action as it shall deem appropriate.

(2) The commission may require a person who formerly held a license but had the license placed on probation, suspended or revoked, to meet and perform certain conditions before reinstating or reissuing a license to this person. These conditions may include, but shall not be limited to satisfactory completion of certain educational requirements, passage of a written examination of the type given to applicants for licensure, personal appearances before and periodic reports to the commission and restitution of money or property.

Chapter 10 — Continuing Education

250-10.010 Requirements

(1) Each real estate licensee who holds an active license shall complete during the two (2)-year license period prior to renewal, as a condition precedent to license renewal, a minimum of twelve (12) hours of real estate instruction approved for continuing education credit by the Missouri Real Estate Commission. An active license is any license issued by the commission except those which have been placed on inactive status by a broker or salesperson, pursuant to 4 CSR 250-4.040(4) and 4 CSR 250-4.060(5). Failure to provide

the commission evidence of course completion as set forth shall constitute grounds for not renewing a license. For purposes of 4 CSR 250-10, an hour is defined as sixty (60) minutes, at least fifty (50) minutes of which shall be devoted to actual classroom instruction and no more than ten (10) minutes of which shall be devoted to a recess. No credit will be allowed for fractional hours.

(2) At least three (3) hours of the twelve (12) hours of approved instruction shall consist of one (1) of the following core curriculum courses, each of which shall include thirty (30) minutes of instruction on current laws and regulations:

(A) Missouri laws governing the transfer of real property;

(B) Broker supervision and escrow account management;

(C) Fair housing;

(D) Propety management; or

(E) Commercial brokerage.

(3) The balance of the twelve (12) hours of instruction shall consist of courses which have been approved for continuing education credit by the Missouri Real Estate Commission. The commission will approve those courses which are determined by it to be those through which real estate licensees can remain qualified and can become more competent to provide a higher level of public service and protection.

(4) Individual licensees may receive continuing education credit for courses taken in Missouri or another state which have not been previously submitted by the sponsor for approval, provided course content, instructor qualifications and course administration are acceptable to the commission. Applications for nonpreapproved course credit must be on a form prescribed by the commission, accompanied by a nonrefundable evaluation fee of ten dollars ($10).

(5) The commission may waive all or part of the continuing education requirements upon a showing by the licensee that it is not feasible for the licensee to satisfy the requirements prior to the renewal date. Waivers may be granted for the following causes:

(A) Serious physical injury or illness;

(B) Active duty in the armed services for an extended period of time;

(C) Residence outside the United States;

(D) Membership in the Missouri Bar;

(E) Licensee is at least eighty (80) years of age;

(F) Licensee has been licensed consecutively since 1942;

(G) Member of the Missouri Senate or House of Representatives at any time during the renewal period to which the waiver applies; and

(H) Member of the Missouri Real Estate Commission during any portion of the renewal period to which the waiver applies.

(6) The following offerings will not be considered by the commission to meet Missouri continuing education requirements even though these offerings may be approved by states with which Missouri enters into continuing education reciprocity:

(A) Training or education not directly related to real estate or real estate practice;

(B) Training or education in office and business skills, such as typing, speedreading, memory improvement, report writing, personal motivation, salesmanship, sales pyschology and time management;

(C) Sales promotions or other meetings held in conjunction with general real estate brokerage activity;

(D) Meetings which are a normal part of in-house training;

(E) That portion of any offering devoted to meals or refreshments;

(F) Sales or brokerage prelicensure education; provided, however, the education will satisfy the continuing education requirement for the license period during which the license was issued to either a new, delinquent or reactivating licensee. Broker applicants who

House Financial Institutions and Insurance Committee
March 16, 1994
Senate Bill 680

Mr. Chair and members of the committee:

My name is Jean Duncan, and I am the Director of the Kansas Real Estate Commission. The commission is opposed to SB-680.

As amended by the Senate committee, it would allow the commission to waive the continuing education requirement for those licensees who are 80 years of age, or older, and who have been licensed for ten years.

Mandatory education requirements are based on the concept that they are in the best interest of the general public whom licensees serve. The C.E. requirement is 12 hours taken during each two-year renewal period. A recent change requires at least 3 of the hours to be on agency relationships and obligations. Licensees do not necessarily have to go to a classroom. There are a number of approved correspondence courses.

Regardless of someone's age or experience, we believe anyone who is active in the business needs continuing education. All licensees need current knowledge to protect consumers in real estate transactions. Further, we do not believe it is good policy to open the door to waivers, thereby inviting others to propose waivers for other groups or reasons.

Thank you for your consideration.

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FLOYD E. GEHRT

March 15, 1994

The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee
State Capitol Building
Room 112S
Topeka, Kansas 66612

RE: S.B. 612

Dear Chairman Bryant:

Please accept this letter on behalf of my client, The Health Insurance Association of American ("HIAA"), in regard to the above bill. As you are aware, 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.

You will recall that S.B. 612 was heard in your committee on March 14, 1994. At that time a representative for the Kansas Psychiatric Society offered a proposed amendment regarding a new mandate relative to psychiatric care. It is to this amendment I wish to address this letter.

Inasmuch as this amendment would require a new mandate, my client would contend that K.S.A. 40-2248 and K.S.A. 40-2249 require a fiscal impact report. The above-mentioned laws require a fiscal impact report so that the legislature may fully evaluate any social benefits versus social costs for such mandates.

You will recall during the hearing the representative proposing the amendment was asked on several occasions what additional costs would be incurred with this proposed change. At the time of the hearing the proponent of the amendment was unable to provide any specific fiscal evaluation.

House F.I.&I.
Attachment 5
March 16, 1994

In addition, this proposed amendment was offered in the Senate hearings when S.B. 612 was being worked in committee. Please be advised that the Senate committee rejected the proposed amendment.

Based upon the foregoing, we would respectfully request that your committee reject the proposed amendment. I appreciate the opportunity to provide you this information, and if you or any member of the committee have any additional questions, please feel free to contact me.

Very truly yours,

GEHRT & ROBERTS, CHARTERED

William W. Sneed

WWS/kjb

As Amended by Senate Committee

Session of 1994

SENATE BILL No. 612

By Senators Praeger and Bond

1-26

AN ACT relating to insurance; sickness and accident plans; small employer health care plans; amending K.S.A. 40-2209, ***40-2209d,*** 40-2209e ~~and,~~ 40-2209f *and* ***40-2209h*** and repealing the existing sections.

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

Section 1. K.S.A. 40-2209 is hereby amended to read as follows: 40-2209. (A) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents. ~~*On and after May 1, 1994, this section shall apply to a group or individual sickness and accident policy, coverage under section 607(1) of the employees retirement income act of 1974 (ERISA), a group specified in K.S.A. 40-2222 and amendments thereto and a group subject to K.S.A. 12-2616 et seq. and amendments thereto.*~~ Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter. No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a waiting period, not to exceed ~~one year~~ for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the 90 days prior to the

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ıployer.

(d) Except as expressly provided in this act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan.

(e) Individual policies of accident and sickness insurance issued to individuals and their dependents totally independent of any group, association or trust arrangement permitted under K.S.A. 40-2209 and amendments thereto shall not be subject to the provisions of this act.

Sec. 3. K.S.A. 40-2209f is hereby amended to read as follows: 40-2209f. Health benefit plans covering small employers that are issued or renewed within this state or outside this state covering persons residing in this state shall be subject to the following provisions, as applicable:

(a) Provisions of preexisting conditions shall not exclude or limit coverage for a period beyond ~~12 months~~ following the individual's effective date of coverage and may only relate to conditions or related conditions for which diagnosis, advice or treatment was sought, during the six months immediately preceding the effective date of coverage. [90 days

(b) Such policy may impose a waiting period, not to exceed ~~one year~~ for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the six months prior to the effective date of coverage. *On and after May 1, 1994,* such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group *or individual* sickness and accident policy, *coverage under section 607(1) of the employees retirement income act of 1974 (ERISA), a group specified in K.S.A. 40-2222 and amendments thereto or a group subject to K.S.A. 12-2616 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 31 days* prior to the effective date of coverage *under a health benefit plan* with no gap in coverage. [90 days

(c) Any health benefit plan issued, delivered or renewed within this state and subject to ~~the provisions of~~ this act, shall be renewble with respect to all eligible employees or dependents at the ɔtion of the policyholder, contractholder, or small employer, except ıor:

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(1) the individual:

(A) Was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(B) states, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(D) requests enrollment within 31 days after the termination of coverage under another employer health benefit plan; or

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(3) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 31 days after issuance of such court order.

(r) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(s) "Plan of operation" means the articles, bylaws and operating rules of the program adopted by the board pursuant to K.S.A. 40-2209l and amendments thereto.

(t) "Preexisting conditions provision" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed ~~*one year*~~ *following the insured's effective date of coverage as to a condition or related conditions for which diagnosis, treatment or advice was sought or received in the six months immediately preceding the effective date of coverage.*

[90 days

(u) "Premium" means moneys paid by a small employer or eligible employees or both as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(v) "Program" means the Kansas small employer health reinsurance program, established under K.S.A. 40-2209l and amendments thereto.

(w) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect but any period of less than one year shall be considered

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a converted policy had the group policy been issued in that jurisdiction.

(21) The insurer shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once during the six-month continuation period in accordance with rules and regulations adopted by the commissioner of insurance.

(E) (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 this subsection shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

Sec. 2. K.S.A. 40-2209e is hereby amended to read as follows: 40-2209e. (a) Any individual or group health benefit plan issued to a group authorized by subsection (A) of K.S.A. 40-2209 and amendments thereto shall be subject to the provisions of this act if it provides health care benefits covering employees of a small employer and if it meets any one of the following conditions:

(1) Any portion of the premium is paid by a small employer, or any covered individual, whether through wage adjustments, reimbursement, withholding or otherwise;

(2) the health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 106 or section 162 of the United States internal revenue code, or

(3) with the permission of the board, the carrier elects to renew or continue a health benefit plan covering employees of an employer who no longer meets the definition of a "small employer."

(b) For purposes of this act an aggregation of two or more small employers covered under a trust arrangement or a policy issued to an association of small employers pursuant to subsection (A)(3) or (5) of K.S.A. 40-2209 and amendments thereto shall permit employee or member units of more than two but less than ~~26~~ *51* employees or members and their dependents to participate in any health benefit plan to which this act applies. Any group which includes employee or member units of ~~25~~ *50* or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than ~~25~~ *50* employees or members.

(c) Except as expressly provided for in this act, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to any SEHC plan offered or delivered to a small

employer.

(d) Except as expressly provided in this act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan.

(e) Individual policies of accident and sickness insurance issued to individuals and their dependents totally independent of any group, association or trust arrangement permitted under K.S.A. 40-2209 and amendments thereto shall not be subject to the provisions of this act.

Sec. 3. K.S.A. 40-2209f is hereby amended to read as follows: 40-2209f. Health benefit plans covering small employers that are issued or renewed within this state or outside this state covering persons residing in this state shall be subject to the following provisions, as applicable:

(a) Provisions of preexisting conditions shall not exclude or limit coverage for a period beyond 12 months following the individual's effective date of coverage and may only relate to conditions or related conditions for which diagnosis, advice or treatment was sought, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a waiting period, not to exceed one year for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought or received in the six months prior to the effective date of coverage. *On and after May 1, 1994,* such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by a group *or individual* sickness and accident policy, *coverage under section 607(1) of the employees retirement income act of 1974 (ERISA), a group specified in K.S.A. 40-2222 and amendments thereto or a group subject to K.S.A. 12-2616 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 31 days* prior to the effective date of coverage *under a health benefit plan* with no gap in coverage.

(c) Any health benefit plan issued, delivered or renewed within this state and subject to ~~the provisions of~~ this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder or small employer, except for:

amendment requested by
Chip Wheelen on behalf of
Kansas Psychiatric Society

(f) Notwithstanding the provisions of subsection (c) of this section or K.S.A. 40-2,105 and amendments thereto, any SEHC plan offered or delivered in this state shall include coverage for diagnosis and medically necessary treatment of mental illnesses.

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optional definition for SB612 re' KPS amendment

For purposes of this act "mental illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain or disability.

drafted by Chip Wheelen
Kansas Psychiatric Society

As Amended by Senate Committee

Session of 1994

SENATE BILL No. 487

By Committee on Financial Institutions and Insurance

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AN ACT relating to health care services; regulation of utilization review organizations.

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

Section 1. This act shall be known and may be cited as the utilization review organization act.

Sec. 2. The legislature finds that in order to promote the delivery of quality health care services in a cost effective manner, it is necessary to encourage greater coordination between health care providers and those agencies performing utilization review of health care services. Effective standards for utilization review activities will protect patients while reducing administrative costs associated with the review and approval of health care services provided to patients.

Sec. 3. For the purposes of this act:

(a) "Commissioner" means the commissioner of insurance.

(b) "Utilization review" means the evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities.

(c) "Utilization review organization" means any entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

(d) "Health care provider" ~~has the meaning provided in K.S.A. 60-513d and amendments thereto~~ means a licensed medical care facility, a licensed health maintenance organization, or a person licensed or registered to engage in an occupation which renders health care services

Sec. 4. (a) The commissioner shall adopt rules and regulations, with the advice ~~and approval~~ of the advisory committee created by section 5, establishing standards governing the conduct of utilization review activities performed in this state or affecting residents of this state by utilization review organizations. Unless granted an exemption under section 6, no utilization review organization may conduct utilization review services in this state or affecting residents of this state on or after May 1, 1995, without first obtaining a certificate from the commissioner.

(b) The commissioner shall not issue a certificate to a utilization review organization until the applicant:

(1) Files a formal application for certification in such form and

amendment drafted by C Streeter

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200e(c)(6) respectively;

4) a person employed or used by a utilization review organization authorized to perform utilization review in Kansas, including, but not limited to, individual nurses and other health care providers. This exemption shall not apply with respect to individual persons performing utilization review activities in conjunction with any insurance contract or health benefit plan pursuant to a direct contractual relationship with a health maintenance organization, group-funded self-insurance plan or insurance company;

(5) a health benefit plan that is self-insured and qualified under the federal employee retirement income security act of 1974 as amended; or

(6) hospitals, home health agencies, clinics, private health care provider offices or any other authorized health care facility or entity conducting general, in-house utilization review unless such review is for the purpose of approving or denying payment for hospital or medical services in a particular case.

(b) The provisions of section 4 (b)(2), (3), (4), (5), (6) and subsection (c) shall not apply to:

(1) Utilization review organizations accredited by and adhering to the national utilization review standards approved by the utilization review accreditation commission (URAC); or

(2) utilization review organizations presenting evidence satisfactory to the commissioner that they subscribe and are adhering to the voluntary guidelines established by the Kansas City private review group. This exemption shall apply only to Kansas City private review group participants located within the Kansas City, Missouri, and Kansas Metropolitan Statistical Area established by the federal Office of Management and Budget as of June 30, 1993; and

(3) such other utilization review organizations as the advisory committee may recommend and the commissioner approves.

Sec. 7. (a) (1) It is unlawful for any person or utilization review organization to perform utilization review activities in this state except in accordance with this act.

(2) No utilization review organization nor any individual performing utilization review activities may agree to be compensated or receive compensation which is contingent in any way upon frequency of certification denials, costs avoided by denial or reduction in payment of claims or other results which may be adverse to the needs of the patient as determined by the attending health care provider.

(b) When the commissioner has reason to believe a utilization review organization subject to this act has been or is engaged in

Amendment drafted by Dick Brock

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(7) utilization review organizations conducting utilization review only with respect to mental health, chemical dependency, chiropractic, optometric, podiatric, dental or any other health care service or services other than the practice of medicine and surgery, until utilization review standards governing such treatment or service are incorporated in rules and regulations adopted pursuant to section 4 of this act.