HOUSE BILL No. 2597

AN ACT concerning insurance; pertaining to the elimination of the errors and omissions requirement for insurance agents; relating to the issuance of insurance policies in a foreign language; relating to risk-based capital requirements; relating to the Kansas uninsurable health insurance plan; relating to the purchase of insurance by state agencies; relating to group health insurance; relating to health benefit plans by the Kansas business health partnership; amending K.S.A. 40-216, 40-241, 40-246b, 40-2,131, 40-2118, 40-2122, 40-2124, 40-2209, 40-4503, 75-4105 and 75-4109 and K.S.A. 2003 Supp. 40-2c01, 40-2404, 40-2404, as amended by section 6 of this act, 40-4702, 40-4704 and 40-4706 and repealing the existing sections; also repealing K.S.A. 40-246f and K.S.A. 2003 Supp. 40-2404, as amended by section 1 of 2004 Senate Bill No. 66.

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

Section 1. K.S.A. 40-241 is hereby amended to read as follows: 40-241. Any applicant or prospective applicant for an agent's license, if an individual, shall be given an examination by the commissioner or the commissioner's designee to determine whether such applicant possesses the competence and knowledge of the kinds of insurance and transactions under the license applied for, or to be applied for, of the duties and responsibilities of such a license and of the pertinent provisions of the laws of this state. The applicant shall be tested on each class or subclassification of insurance which may be written. An examination fee prescribed in rules and regulations adopted by the commissioner shall be paid by the applicant and shall be required for each class of insurance for each attempt to pass the examination. Such examination fee shall be in addition to the certification fee required under K.S.A. 40-252, and amendments thereto. There shall be four classes of insurance for the purposes of this act:

(1) Life;

(2) accident and health;

(3) casualty and allied lines; and

(4) property and allied lines.

An insurance license may be issued as a subclassification of casualty and allied lines to any auto rental agency. An auto rental agency may offer or sell insurance only in connection with and incidental to the rental of motor vehicles, whether at the rental office, at the point of delivery of a vehicle, or by preselection of coverage in a master, corporate or group rental agreement, in any of the following general categories: (1) Personal accident insurance covering risks of travel, (2) motor vehicle liability insurance, (3) personal effects insurance providing coverage to renters and other occupants of the motor vehicle, (4) roadside assistance and emergency sickness protection programs, and (5) any other travel or auto-related coverage an auto rental company may offer in connection with and incidental to rental of motor vehicles. No insurance may be issued by an auto rental agency unless the rental period of the rental agreement does not exceed 90 consecutive days and brochures and other written material clearly and correctly explaining insurance coverages offered by the agency are available for prospective renters and clear and complete disclosures are provided to prospective renters that such coverage may be duplicative of other insurance owned by the renter, that purchase of insurance coverage is not a condition for renting a motor vehicle and describing the process for filing a claim.

Auto rental agencies employing representatives shall conduct a training program for each representative, providing instruction on the kinds of insurance coverage offered by the agency.

No auto rental agency shall offer or solicit any insurance other than the coverages described in this section without an insurance license. No auto rental employee or auto rental agency shall advertise or otherwise hold themselves out as licensed insurers, insurance agents or insurance brokers.

The commissioner of insurance shall adopt rules and regulations with respect to the scope, subclassification, type and conduct of such examination. Examinations shall be given to applicants at least twice a month in Topeka, Kansas, and at least quarterly in other convenient locations in the state of Kansas. The commissioner shall publish or arrange for the publication of information and material which applicants can use to prepare for such examination. One or more rating organizations, advisory organizations or other associations may be designated by the commissioner to assist in, or assume responsibility for, distribution of the study manuals to applicants and other interested parties. Persons purchasing the study manual shall be charged a reasonable fee established or ap-

proved by the commissioner. In the event the publication and distribution of the study material or the development and conduct of examinations is delegated to private firms, organizations or associations and the state incurs no expense or obligation, the provisions of K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto, shall not apply. If the commissioner of insurance finds that the individual applicant is trustworthy, competent and has satisfactorily completed the examination, the commissioner shall forthwith issue to the applicant a license as an insurance agent but the issuance of such license shall confer no authority to transact business in this state until the agent has been certified by a company pursuant to K.S.A. 40-241i, and amendments thereto ~~and submitted proof that the agent is covered by an errors and omissions policy required by this section~~. If such applicant fails to satisfactorily complete the examination, the examination may be retaken following a waiting period of not less than seven days from the date of the last attempt. If the applicant again fails to satisfactorily complete the examination, it may be retaken following another waiting period of not less than seven days from the date of the most recent attempt. Thereafter, the examination may be retaken following a waiting period of not less than six months from the date of the most recent attempt, except that following a waiting period of two years from the date of the applicant's last examination attempt an applicant will be treated as a new applicant and new examination and waiting periods shall apply. ~~While licensed every agent shall be covered by an errors and omissions policy covering the individual agent in an amount of not less than $100,000 total liability limit per occurrence, subject to not less than $100,000 annual aggregate for all claims made during the policy period; or, covering the agent under blanket liability policy or policies, which policy or policies can include other coverage on an excess basis over $100,000 primary, insuring other insurance agents or brokers in an amount of not less than $500,000 total liability limit per occurrence subject to not less than $500,000 annual aggregate for all claims made during the policy period. Such policy shall be issued by an authorized insurance company or as authorized by K.S.A. 40-246b or 40-246e, and amendments thereto, for errors and omissions of the agent. Self-retention shall be permitted on liability policies covering the agent.~~

Sec. 2. K.S.A. 40-246b is hereby amended to read as follows: 40-246b. The commissioner of insurance may issue to any duly licensed resident agent of this state, who has been licensed as a fire or casualty, or both, resident agent in this or any other state or combination thereof, for three consecutive years immediately prior to application for the type of license herein prescribed, upon proper application, an excess coverage license to negotiate the types of contracts of fire insurance enumerated in K.S.A. 40-901, and amendments thereto, and the type of casualty insurance contracts enumerated in K.S.A. 40-1102, and amendments thereto, or reinsurance, or to place risks, or to effect insurance or reinsurance for persons or corporations other than such agent, with insurers not authorized to do business in this state. An agent, as defined in K.S.A. 40-241e, and amendments thereto, may place the kind or kinds of business specified in this act for which such agent is licensed pursuant to K.S.A. 40-240 and 40-241, and amendments thereto, with an insurer not authorized to do business in this state by placing such business with a person licensed pursuant to the provisions of this act and may share in the applicable commissions on such business. Before any such license shall be issued, the applicant shall submit proper application on a form prescribed by the commissioner, which application shall be accompanied by a fee of $50. Such license shall be renewable each year on May 1, upon the payment of a $50 fee ~~and certification of appropriate errors and omissions coverage as required by K.S.A. 40-246f, and amendments thereto~~. Excess lines agents licensed by the department on the effective date of this act shall be exempt from the experience requirement.

The agent so licensed shall on or before March 1 of each year, file with the insurance department of this state, a sworn affidavit or statement to the effect that, after diligent effort, such agent has been unable to secure the amount of insurance required to protect the property, person, or firm described in such agent's affidavit or statement from loss or damage in regularly admitted companies during the preceding year. Mere rate differential shall not be grounds for placing a particular risk in a nonadmitted

carrier when an admitted carrier would accept such risk at a different rate. The licensed excess coverage agent must, prior to placing insurance with an insurer not authorized to do business in this state, obtain the written consent of the prospective named insured and provide such insured the following information in a form promulgated by the commissioner:

(a) A statement that the coverage will be obtained from an insurer not authorized to do business in this state;

(b) a statement that the insurer's name appears on the list of companies maintained by the commissioner pursuant to K.S.A. 40-246e, and amendments thereto;

(c) a notice that the insurer's financial condition, policy forms, rates and trade practices are not subject to the review or jurisdiction of the commissioner;

(d) a statement that the protection of the guaranty associations is not afforded to policyholders of the insurer; and

(e) a statement or notice with respect to any other information deemed necessary by the commissioner pertinent to insuring with an insurer not authorized to do business in this state.

In the event the insured desires that coverage be bound with an insurer not admitted to this state and it is not possible to obtain the written consent of the insured prior to binding the coverage, the excess lines agent may bind the coverage after advising the insured of the information set out above and shall obtain written confirmation that the insured desires that coverage be placed with an insurer not admitted to this state within 30 days after binding coverage.

When business comes to a licensed excess lines agent for placement with an insurer not authorized to do business in this state from an agent not licensed as an excess lines agent, it shall be the responsibility of the licensed excess lines agent to ascertain that the insured has been provided the preceding information and has consented to being insured with an insurer not authorized to do business in this state. Each excess lines agent shall keep a separate record book in such agent's office showing the transactions of fire and casualty insurance and reinsurance placed in companies not authorized to do business in this state, the amount of gross premiums charged thereon, the insurer in which placed, the date, term and number of the policy, the location and nature of the risk, the name of the assured and such other information as the commissioner may require and such record shall be available at all times for inspection by the commissioner of insurance or the commissioner's authorized representatives. The commissioner may revoke or suspend any license issued pursuant to the provisions of this act in the same manner and for the same reasons prescribed by K.S.A. 40-242, and amendments thereto.

Any policy issued under the provisions of this statute shall have stamped or endorsed in a prominent manner thereon, the following: This policy is issued by an insurer not authorized to do business in Kansas and, as such, the form, financial condition and rates are not subject to review by the commissioner of insurance and the insured is not protected by any guaranty fund.

If business is placed with a nonadmitted company that is subsequently determined to be insolvent, the excess lines agent placing such business with such company is relieved of any responsibility to the insured as it relates to such insolvency, if the excess lines agent has satisfactorily complied with all requirements of this section pertaining to notification of the insured, has properly obtained the written consent of the insured and has used due diligence in selecting the insurer. It shall be presumed that due diligence was used in selecting the insurer if such insurer was on the list compiled pursuant to K.S.A. 40-246e, and amendments thereto, at the time coverage first became effective.

Sec. 3. K.S.A. 40-2,131 is hereby amended to read as follows: 40-2,131. (a) No person, firm, association or corporation shall act in the capacity of an MGA with respect to risks located in this state for an insurer licensed in this state unless such person is a licensed agent or broker in this state.

(b) No person, firm, association or corporation shall act in the capacity of an MGA representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as an

agent or broker in this state pursuant to the provisions of K.S.A. 40-240 or 40-3701 *et seq.*, and amendments thereto.

(c) The commissioner may require a bond in an amount acceptable to the commissioner for the protection of the insurer.

~~(d) The commissioner may require the MGA to maintain an errors and omissions policy.~~

Sec. 4. K.S.A. 40-4503 is hereby amended to read as follows: 40-4503. (a) No person, firm, association or corporation shall act as a reinsurance broker in this state if the reinsurance broker maintains an office either directly or as a member or employee of a firm or association, or as an officer, director or employee of a corporation:

(1) In this state, unless such reinsurance broker is a licensed producer in this state; or

(2) in another state, unless such reinsurance broker is a licensed producer in this state or another state having a law substantially similar to this act or such reinsurance broker is licensed in this state as a nonresident reinsurance intermediary.

(b) No person, firm, association or corporation shall act as a reinsurance manager:

(1) For a reinsurer domiciled in this state, unless such reinsurance manager is a licensed producer in this state;

(2) in this state, if the reinsurance manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless such reinsurance manager is a licensed producer in this state;

(3) in another state for a nondomestic insurer, unless such reinsurance manager is a licensed producer in this state or another state having a law substantially similar to this act or such person is licensed in this state as a nonresident reinsurance intermediary.

(c) The commissioner may require a reinsurance manager subject to subsection (b) to~~:~~

~~(1)~~ file a bond in an amount from an insurer acceptable to the commissioner for the protection of each reinsurer represented~~; and~~

~~(2) maintain an errors and omissions policy in an amount acceptable to the commissioner~~.

(d) (1) The commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of this act. Before any such license may be issued, the applicant shall submit proper application therefor on a form prescribed by the commissioner which shall be accompanied by an initial fee of $150. Any license so issued shall remain in effect until suspended, revoked, voluntarily surrendered or otherwise terminated by the commissioner or licensee subject to payment of an annual continuation fee of $100 on or before May 1 of each year. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof, to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(2) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, as is provided for by this act for designation of service of process upon insurers holding a Kansas certificate of authority. Such applicant shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the commissioner.

(e) The commissioner may, after a hearing conducted in accordance with the provisions of the Kansas administrative procedure act, held on not less than 20 days notice, refuse to issue a reinsurance intermediary

license if, in the judgment of the commissioner, the applicant, any one named on the application, or any member, principal, officer or director of the applicant, is not trustworthy, or any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license.

(f) Licensed attorneys at law in this state when acting in their professional capacity as such shall be exempt from this section.

Sec. 5. From and after July 1, 2004, K.S.A. 40-216 is hereby amended to read as follows: 40-216. (a) No insurance company shall hereafter transact business in this state until certified copies of its charter and amendments thereto shall have been filed with and approved by the commissioner of insurance. A copy of the bylaws and amendments thereto of insurance companies organized under the laws of this state shall also be filed with and approved by the commissioner of insurance. The commissioner may also require the filing of such other documents and papers as are necessary to determine compliance with the laws of this state. No contract of insurance or indemnity shall be issued or delivered in this state until the form of the same has been filed with the commissioner of insurance, nor if the commissioner of insurance gives written notice within 30 days of such filing, to the company proposing to issue such contract, showing wherein the form of such contract does not comply with the requirements of the laws of this state; but the failure of any insurance company to comply with this section shall not constitute a defense to any action brought on its contracts. An insurer may satisfy its obligation to file its contracts of insurance or indemnity either individually or by authorizing the commissioner to accept on its behalf the filings made by a licensed rating organization or another insurer.

Under such rules and regulations as the commissioner of insurance shall adopt, the commissioner may, by written order, suspend or modify the requirement of filing forms of contracts of insurance or indemnity, which cannot practicably be filed before they are used. Such orders, rules and regulations shall be made known to insurers and rating organizations affected thereby. The commissioner may make an examination to ascertain whether any forms affected by such order meet the standards of this code.

(b) ~~Prior to the 2000 legislative session, the Kansas insurance department shall conduct a study and report to the Kansas legislature on the laws of other states governing rate filings and policy or contract forms for personal and commercial, including large commercial risks. The study shall also identify recent trends in regulation and the potential impact on consumers, carriers and agents.~~ *The commissioner of insurance shall allow any insurance company authorized to transact business in this state to deliver to any person in this state any contract of insurance or indemnity, including any explanatory materials, written in any language other than the English language under the following conditions:*

(1) The insured or applicant for insurance who is given a copy of the same contract of insurance or indemnity or explanatory materials written in the English language;

(2) the English language version of the contract for insurance or indemnity or explanatory materials delivered shall be the controlling version; and

(3) any contract of insurance or indemnity or explanatory materials written in any language other than English shall contain a disclosure statement in 10 point boldface type, printed in both the English language and the other language used, stating the English version of the contract of insurance or indemnity is the official or controlling version and that the version is written in any language other than English is furnished for informational purposes only.

(c) All contracts of insurance or indemnity that are required to be filed with the commissioner of insurance shall be accompanied by any version of such contract of insurance or indemnity written in any language other than the English language.

(d) Any insurance company or insurer, including any agent or employee thereof, who knowingly misrepresents the content of a contract of insurance or indemnity or explanatory materials written in a language

other than the English language shall be deemed to have violated the unfair trade practice law.

(e) For the purposes of this section, the term "contract of insurance or indemnity" shall include any rider, endorsement or application pertaining to such contract of insurance or indemnity.

Sec. 6. From and after July 1, 2004, K.S.A. 2003 Supp. 40-2404 is hereby amended to read as follows: 40-2404. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies.* Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.

(3) *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) *Boycott, coercion and intimidation.* Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) *False statements and entries.* (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or

advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.

(7) *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(d) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for accident and health and life insurance to an applicant who is the proposed insured or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse, except as provided in subpart (v). "Abuse" as used in this subsection (7)(d) means one or more acts defined in subsection (a) or (b) of K.S.A. 60-3102 and amendments thereto between family members, current or former household members, or current or former intimate partners.

(i) An insurer may not ask an applicant for life or accident and health insurance who is the proposed insured if the individual is, has been or may be the subject of domestic abuse or seeks, has sought or had reason to seek medical or psychological treatment or counseling specifically for abuse, protection from abuse or shelter from abuse.

(ii) Nothing in this section shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is, has been or has the potential to be the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy.

(iii) No insurer that issues a life or accident and health policy to an individual who is, has been or may be the subject of domestic abuse shall be subject to civil or criminal liability for the death or any injuries suffered by that individual as a result of domestic abuse.

(iv) No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles.

(v) Nothing in this section shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition has been caused by abuse, provided that:

(A) The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse;

(B) the fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and

(C) such underwriting or rating is not used to evade the intent of this section or any other provision of the Kansas insurance code.

(vi) Any person who underwrites or rates a risk on the basis of preexisting physical or mental condition as set forth in subsection (7)(d)(v), shall treat such underwriting or rating as an adverse underwriting decision pursuant to K.S.A. 40-2,112, and amendments thereto.

(vii) The provisions of subsection (d) shall apply to all policies of life and accident and health insurance issued in this state after the effective date of this act and all existing contracts which are renewed on or after the effective date of this act.

(8) *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *Failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) *Misrepresentation in insurance applications.* Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) *Statutory violations.* Any violation of any of the provisions of K.S.A. *40-216,* 40-276a, *40-2,155 or* 40-1515 ~~or K.S.A. 40-2,155~~ and amendments thereto.

(13) *Disclosure of information relating to adverse underwriting decisions and refund of premiums.* Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the time prescribed in such section.

(14) *Rebates and other inducements in title insurance.* (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in (14)(a).

(c) Nothing in this section shall be construed as prohibiting:

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or

more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

(e) No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.

(f) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) 20% or more of the gross operating revenue of that title insurer or title agent during the six full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.

(g) The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* (a) No person shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with and not more restrictive than the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation".

(b) Any rules and regulations adopted by the commissioner which implement article V of the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation" shall become effective on and after February 1, 2002.

(c) Nothing in this paragraph (15) shall be deemed or construed to authorize the promulgation or adoption of any regulation which preempts, supersedes or is inconsistent with any provision of Kansas law concerning requirements for notification of, or obtaining consent from, a parent, guardian or other legal custodian of a minor relating to any matter pertaining to the health and medical treatment for such minor.

Sec. 7. From and after July 1, 2004, K.S.A. 2003 Supp. 40-2c01 is hereby amended to read as follows: 40-2c01. As used in this act:

(a) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with K.S.A. 40-2c04, and amendments thereto.

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required to address a RBC level event.

(c) "Domestic insurer" means any insurance company or risk retention group which is licensed and organized in this state.

(d) "Foreign insurer" means any insurance company or risk retention group not domiciled in this state which is licensed or registered to do business in this state pursuant to article 41 of chapter 40 of the Kansas Statutes Annotated or K.S.A. 40-209, and amendments thereto.

(e) "NAIC" means the national association of insurance commissioners.

(f) "Life and health insurer" means any insurance company licensed under article 4 or 5 of chapter 40 of the Kansas Statutes Annotated or a licensed property and casualty insurer writing only accident and health insurance.

(g) "Property and casualty insurer" means any insurance company licensed under articles 9, 10, 11, 12, 12a, 15 or 16 of chapter 40 of the

Kansas Statutes Annotated, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions defined in subsection (j).

(i) "RBC" means risk-based capital.

(j) "RBC instructions" mean the risk-based capital instructions promulgated by the NAIC, which are in effect on December 31, ~~2002~~ *2003*.

(k) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(l) "RBC plan" means a comprehensive financial plan containing the elements specified in K.S.A. 40-2c06, and amendments thereto. If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(m) "RBC report" means the report required by K.S.A. 40-2c02, and amendments thereto.

(n) "Total adjusted capital" means the sum of:

(1) An insurer's capital and surplus or surplus only if a mutual insurer; and

(2) such other items, if any, as the RBC instructions may provide.

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

Sec. 8. K.S.A. 40-2118 is hereby amended to read as follows: 40-2118. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

(a) "Administering carrier" means the insurer or third-party administrator designated in K.S.A. 40-2120, and amendments thereto.

(b) "Association" means the Kansas health insurance association established in K.S.A. 40-2119, and amendments thereto.

(c) "Board" means the board of directors of the association.

(d) "Church plan" means a plan as defined under section 3(33) of the Employee Retirement Income Security Act of 1974.

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

(f) "Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan~~.~~*;*

(2) health insurance coverage;

(3) part A or part B of Title XVIII of the Social Security Act;

(4) title XIX of the Social Security Act, other than coverage consisting solely of benefit under Section 1928;

(5) chapter 55 of Title 10, United States Code;

(6) a medical care program of the Indian Health Service or of a tribal organization;

(7) a state health benefit risk pool;

(8) a health plan offered under Chapter 89 of Title 5, United States Code;

(9) a public health plan as defined under regulations promulgated by the secretary of health and human services; and

(10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d)).

(g) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 23 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(h) ~~"Federally defined eligible individual" means an individual.~~

~~(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and whose most recent prior coverage was under a group health plan, government plan or church plan;~~

~~(2) who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;~~

~~(3) with respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and~~

~~(4) who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.~~

~~(i)~~ "Excess loss" means the total dollar amount by which claims expense incurred for any issuer of a medicare supplement policy or certificate delivered or issued for delivery to persons in this state eligible for medicare by reason of disability and who are under age 65 exceeds 65% of the premium earned by such issuer during a calendar year.

(i) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and whose most recent prior coverage was under a group health plan, government plan or church plan;

(2) who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(3) with respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(4) who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.

(j) "Federally defined eligible individuals for FTAA" means an individual who is:

(1) Legally domiciled in this state; and

(2) eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986.

~~(j)~~ *(k) "FTAA" means federal trade adjustment assistance under the federal trade adjustment assistance reform act of 2002, public law 107-210.*

(l) "Governmental plan" means a plan as defined under section 3(32) of the Employee Retirement Income Security Act of 1974 and any plan maintained for its employees by the government of the United States or by any agency or instrumentality of such government.

~~(k)~~ *(m)* "Group health plan" means an employee benefit plan as defined by section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides any hospital, surgical or medical expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

~~(l)~~ *(n)* "Health insurance" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health insurance" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

~~(m)~~ *(o)* "Health maintenance organization" means any organization granted a certificate of authority under the provisions of the health maintenance organization act.

~~(n)~~ *(p)* "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions

or other organizations provide to their employees or members, either directly or indirectly through a group-funded pool, trust or third-party administrator, health care services or benefits other than through an insurer.

~~(o)~~ *(q)* "Insurer" means any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance business in this state.

~~(p)~~ *(r)* "Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.

~~(q)~~ *(s)* "Medicare" means coverage under both parts A and B of title XVIII of the federal social security act, 42 USC 1395.

~~(r)~~ *(t)* "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospitals and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 USC 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

~~(s)~~ *(u)* "Member" means all insurers and insurance arrangements participating in the association.

~~(t)~~ *(v)* "Plan" means the Kansas uninsurable health insurance plan created pursuant to this act.

~~(u)~~ *(w)* "Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, bylaws and operating rules, adopted by the board pursuant to K.S.A. 40-2119, and amendments thereto.

Sec. 9. K.S.A. 40-2122 is hereby amended to read as follows: 40-2122. (a) The following individuals shall be eligible for plan coverage provided they meet the criteria set forth in subsection (b):

(1) Any person who has been a resident of this state for at least six months;

(2) any person who is a legal domiciliary of this state who previously was covered under the high risk pool of another state, provided they apply for coverage under the plan within 63 days of losing such other coverage for reasons other than fraud or nonpayment of premiums; ~~or~~

(3) any federally defined eligible individual who is a legal domiciliary of this state*; or*

(4) any federally defined eligible individual for FTAA.

(b) Those individuals who are eligible for plan coverage under subsection (a) must provide evidence satisfactory to the administering carrier that such person meets one of the following criteria:

(1) Such person has had health insurance coverage involuntarily terminated for any reason other than nonpayment of premium;

(2) such person has applied for health insurance and been rejected by two carriers because of health conditions;

(3) such person has applied for health insurance and has been quoted a premium rate which is in excess of the plan rate;

(4) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition; ~~or~~

(5) such person is a federally defined eligible individual*; or*

(6) such person is a federally defined eligible individual for FTAA.

(c) Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

(d) The following persons shall not be eligible for coverage under the plan:

(1) Any person who is eligible for medicare or is eligible for medicaid benefits;

(2) any person who has had coverage under the plan terminated less than 12 months prior to the date of the current application, except that this provision shall not apply with respect to an applicant who is a federally defined eligible individual;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by K.S.A. 40-2124 and amendments thereto;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan*, including coverage under the consolidated omnibus budget reconciliation act (COBRA), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person:*

(A) Is eligible for the credit for health care costs under section 35 of the internal revenue code of 1986; and

(B) has three months of prior creditable coverage as described in subsection (c) of K.S.A. 40-2124, and amendments thereto; or

(5) any person who is eligible for any other public or private program that provides or indemnifies for health services.

(e) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of a policy period.

(f) All plan members, insurers and insurance arrangements shall notify in writing persons denied health insurance coverage, for any reason, of the availability of coverage through the Kansas health insurance association.

Sec. 10. K.S.A. 40-2124 is hereby amended to read as follows: 40-2124. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. On and after January 1, 1998, the plan shall offer to current participants and new enrollees no fewer than four choices of deductible and copayment options. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop-loss provision. Such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $1,000,000 per covered individual.

(c) On and after May 1, 1994, coverage under the plan shall exclude charges or expenses incurred during the first 90 days following the effective date of coverage as to any condition: (1) Which manifested itself during the six-month period immediately prior to the application for coverage in such manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions may be excluded as determined by the board, except that no such exclusion shall exceed 180 calendar days, and no exclusion shall be applied to a federally defined eligible individual provided that application for coverage is made not later than 63 days following the applicant's most recent prior creditable coverage. *For any individual who is eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986, the preexisting conditions limitation will not apply whenever such individual has maintained creditable health insurance coverage for an aggregate period of three months, not counting any period prior to a 63 day break in coverage, as of the date on which such individual seeks to enroll in coverage provided by this act.*

(d) (1) Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The association shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this section.

Sec. 11. From and after July 1, 2004, K.S.A. 40-2209 is hereby amended to read as follows: 40-2209. (a) (1) 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. 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.

(2) An eligible employee, member or dependent who requests enrollment following the open enrollment opportunity or any special enrollment period for dependents as specified in subsection (3) shall be considered a late enrollee. An accident and sickness insurer may exclude a late enrollee, except during an open enrollment period. However, an eligible employee, member or dependent shall not be considered a late enrollee if:

(A) The individual:

(i) Was covered under another group policy which provided hospital, medical or surgical expense benefits or was covered under section 607(1) of the employee retirement income security act of 1974 (ERISA) at the time the individual was eligible to enroll;

(ii) states in writing, at the time of the open enrollment period, that coverage under another group policy which provided hospital, medical or surgical expense benefits was the reason for declining enrollment, but only if the group policyholder or the accident and sickness insurer required such a written statement and provided the individual with notice of the requirement for a written statement and the consequences of such written statement;

(iii) has lost coverage under another group policy providing hospital, medical or surgical expense benefits or under section 607(1) of the employee retirement income security act of 1974 (ERISA) as a result of the termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, the termination of the other policy's coverage, death of a spouse or divorce or legal separation or was under a COBRA continuation provision and the coverage under such provision was exhausted; and

(iv) requests enrollment within 30 days after the termination of coverage under the other policy; or

(B) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's or member's policy.

(3) (A) If an accident and sickness insurer issues a group policy providing hospital, medical or surgical expenses and makes coverage available to a dependent of an eligible employee or member and such dependent becomes a dependent of the employee or member through marriage, birth, adoption or placement for adoption, then such group policy shall provide for a dependent special enrollment period as described in subsection (3) (B) of this section during which the dependent may be enrolled under the policy and in the case of the birth or adoption of a child, the spouse of an eligible employee or member may be enrolled if otherwise eligible for coverage.

(B) A dependent special enrollment period under this subsection shall be a period of not less than 30 days and shall begin on the later of (i) the date such dependent coverage is made available, or (ii) the date of the marriage, birth or adoption or placement for adoption.

(C) If an eligible employee or member seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective: (i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received; (ii) in the case of the birth of a dependent, as of the date of such birth; or (iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(4) (A) 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 preexisting conditions

exclusion, not to exceed 90 days following the date of enrollment for benefits for conditions whether mental or physical, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of enrollment. Any preexisting conditions exclusion shall run concurrently with any waiting period.

(B) Such policy may impose a waiting period after full-time employment starts before an employee is first eligible to enroll in any applicable group policy.

(C) A health maintenance organization which offers such policy which does not impose any preexisting conditions exclusion may impose an affiliation period for such coverage, provided that: (i) such application period is applied uniformly without regard to any health status related factors and (ii) such affiliation period does not exceed two months. The affiliation period shall run concurrently with any waiting period under the plan.

(D) A health maintenance organization may use alternative methods from those described in this subsection to address adverse selection if approved by the commissioner.

(E) For the purposes of this section, the term "preexisting conditions exclusion" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(F) For the purposes of this section, the term "date of enrollment" means the date the individual is enrolled under the group policy or, if earlier, the first day of the waiting period for such enrollment.

(G) For the purposes of this section, the term "waiting period" means with respect to a group policy the period which must pass before the individual is eligible to be covered for benefits under the terms of the policy.

(5) Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

(6) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(7) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition waiting period in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of a 30-day period beginning on the date of the adoption or placement for adoption, is covered by a policy specified in subsection (a). This subsection shall not apply to coverage before the date of such adoption or placement for adoption.

(8) Such policy shall waive such a preexisting conditions exclusion to the extent the employee or member or individual dependent or family member was covered by (A) a group or individual sickness and accident policy, (B) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA), (C) a group specified in K.S.A. 40-2222 and amendments thereto, (D) part A or part B of title XVIII of the social security act, (E) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, (F) a state children's health insurance program established pursuant to title XXI of the social security act, (G) chapter 55 of title 10 United States code, (H) a medical care program of the indian health service or of a tribal organization, (I) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 *et seq.* and amendments thereto or a similar health benefits risk pool of another state, (J) a health plan offered under chapter 89 of title 5, United States code, (K) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e), or (L) a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within 63 days prior to the effective date of coverage with no gap in coverage. A group policy shall credit the periods of prior coverage specified in subsection (a)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.

(b) (1) An accident and sickness insurer which offers group policies providing hospital, medical or surgical expense benefits shall provide a certification as described in subsection (b)(2): (A) At the time an eligible employee, member or dependent ceases to be covered under such policy or otherwise becomes covered under a COBRA continuation provision; (B) in the case of an eligible employee, member or dependent being covered under a COBRA continuation provision, at the time such eligible employee, member or dependent ceases to be covered under a COBRA continuation provision; and (C) on the request on behalf of such eligible employee, member or dependent made not later than 24 months after the date of the cessation of the coverage described in subsection (b)(1) (A) or (b)(1) (B), whichever is later.

(2) The certification described in this subsection is a written certification of (A) the period of coverage under a policy specified in subsection (a) and any coverage under such COBRA continuation provision, and (B) any waiting period imposed with respect to the eligible employee, member or dependent for any coverage under such policy.

(c) Any group policy may impose participation requirements, define full-time employees or members and otherwise be designed for the group as a whole through negotiations between the group sponsor and the insurer to the extent such design is not contrary to or inconsistent with this act.

(d) (1) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits must renew or continue in force such coverage at the option of the policyholder or certificateholder except as provided in paragraph (2) below.

(2) An accident and sickness insurer may nonrenew or discontinue coverage under a group policy providing hospital, medical or surgical expense benefits based only on one or more of the following circumstances:

(A) If the policyholder or certificateholder has failed to pay any premium or contributions in accordance with the terms of the group policy providing hospital, medical or surgical expense benefits or the accident and sickness insurer has not received timely premium payments;

(B) if the policyholder or certificateholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of such coverage;

(C) if the policyholder or certificateholder has failed to comply with a material plan provision relating to employer contribution or group participation rules;

(D) if the accident and sickness insurer is ceasing to offer coverage in such group market in accordance with subsections (d)(3) or (d)(4);

(E) in the case of accident and sickness insurer that offers coverage under a policy providing hospital, medical or surgical expense benefits through an enrollment area, there is no longer any eligible employee, member or dependent in connection with such policy who lives, resides or works in the medical service enrollment area of the accident and sickness insurer or in the area for which the accident and sickness insurer is authorized to do business; or

(F) in the case of a group policy providing hospital, medical or surgical expense benefits which is offered through an association or trust pursuant to subsections (f)(3) or (f)(5), the membership of the employer in such association or trust ceases but only if such coverage is terminated uniformly without regard to any health status related factor relating to any eligible employee, member or dependent.

(3) In any case in which an accident and sickness insurer which offers a group policy providing hospital, medical or surgical expense benefits decides to discontinue offering such type of group policy, such coverage may be discontinued only if:

(A) The accident and sickness insurer notifies all policyholders and certificateholders and all eligible employees or members of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the accident and sickness insurer offers to each policyholder who is provided such group policy providing hospital, medical or surgical expense benefits which is being discontinued the option to purchase any other group policy providing hospital, medical or surgical expense benefits currently being offered by such accident and sickness insurer; and

(C) in exercising the option to discontinue coverage and in offering the option of coverage under subparagraph (B), the accident and sickness insurer acts uniformly without regard to the claims experience of those policyholders or certificateholders or any health status related factors relating to any eligible employee, member or dependent covered by such group policy or new employees or members who may become eligible for such coverage.

(4) If the accident and sickness insurer elects to discontinue offering group policies providing hospital, medical or surgical expense benefits or group coverage to a small employer pursuant to K.S.A. 40-2209f and amendments thereto, such coverage may be discontinued only if:

(A) The accident and sickness insurer provides notice to the insurance commissioner, to all policyholders or certificateholders and to all eligible employees and members covered by such group policy providing hospital, medical or surgical expense benefits at least 180 days prior to the date of the discontinuation of such coverage;

(B) all group policies providing hospital, medical or surgical expense benefits offered by such accident and sickness insurer are discontinued and coverage under such policies are not renewed; and

(C) the accident and sickness insurer may not provide for the issuance of any group policies providing hospital, medical or surgical expense benefits in the discontinued market during a five year period beginning on the date of the discontinuation of the last such group policy which is nonrenewed.

(e) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits may not establish rules for eligibility (including continued eligibility) of any employee, member or dependent to enroll under the terms of the group policy based on any of the following factors in relation to the eligible employee, member or dependent: (A) Health status, (B) medical condition, including both physical and mental illness, (C) claims experience, (D) receipt of health care, (E) medical history, (F) genetic information, (G) evidence of insurability, including conditions arising out of acts of domestic violence, or (H) disability. This subsection shall not be construed to require a policy providing hospital, medical or surgical expense benefits to provide particular benefits other than those provided under the terms of such group policy or to prevent a group policy providing hospital, medical or surgical expense benefits from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled under the group policy.

(f) Group accident and health insurance may be offered to a group under the following basis:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least two employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(2) Under a policy issued to a labor union which shall have a constitution and bylaws insuring at least 25 members of such union.

(3) Under a policy issued to the trustees of a fund established by two or more employers or business associations or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be the policyholder, to insure employees of the employers or members of the union or members of the association for the benefit of persons other than the employers or the unions or the associations. The term "employees" shall include the officers, managers, employees and retired employees of the employer and the individual proprietor or

partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) A policy issued to a creditor, who shall be deemed the policyholder, to insure debtors of the creditor, subject to the following requirements: (a) The debtors eligible for insurance under the policy shall be all of the debtors of the creditor whose indebtedness is repayable in installments, or all of any class or classes determined by conditions pertaining to the indebtedness or to the purchase giving rise to the indebtedness. (b) The premium for the policy shall be paid by the policyholder, either from the creditor's funds or from charges collected from the insured debtors, or from both.

(5) A policy issued to an association which has been organized and is maintained for the purposes other than that of obtaining insurance, insuring at least 25 members, employees, or employees of members of the association for the benefit of persons other than the association or its officers. The term "employees" shall include retired employees. The premiums for the policies shall be paid by the policyholder, either wholly from association funds, or funds contributed by the members of such association or by employees of such members or any combination thereof.

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract.

(g) Each such policy shall contain in substance: (1) A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the insured's beneficiary.

(2) A provision setting forth the conditions under which an individual's coverage terminates under the policy, including the age, if any, to which an individual's coverage under the policy shall be limited, or, the age, if any, at which any additional limitations or restrictions are placed upon an individual's coverage under the policy.

(3) Provisions setting forth the notice of claim, proofs of loss and claim forms, physical examination and autopsy, time of payment of claims, to whom benefits are payable, payment of claims, change of beneficiary, and legal action requirements. Such provisions shall not be less favorable to the individual insured or the insured's beneficiary than those corresponding policy provisions required to be contained in individual accident and sickness policies.

(4) A provision that the insurer will furnish to the policyholder, for the delivery to each employee or member of the insured group, an individual certificate approved by the commissioner of insurance setting forth in summary form a statement of the essential features of the insurance coverage of such employee or member, the procedure to be followed in making claim under the policy and to whom benefits are payable. Such certificate shall also contain a summary of those provisions required under paragraphs (2) and (3) of this subsection (g) in addition to the other essential features of the insurance coverage. If dependents are included in the coverage, only one certificate need be issued for each family unit.

(h) No group disability income policy which integrates benefits with social security benefits, shall provide that the amount of any disability benefit actually being paid to the disabled person shall be reduced by changes in the level of social security benefits resulting either from changes in the social security law or due to cost of living adjustments which become effective after the first day for which disability benefits become payable.

(i) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group

policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of six months and have issued to the employee or member or such employee's or member's covered dependents by the insurer, at the end of such six-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides benefits for specific diseases or for accidental injuries only or a group policy issued to an employer subject to the continuation and conversion obligations set forth at title I, subtitle B, part 6 of the employee retirement income security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987 to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights; or an employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because:

(1) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (2) any discontinued group coverage was replaced by similar group coverage within 31 days; (3) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); ~~or~~ (4) the employee or member is or could be covered to the same extent by any other insured or lawful self-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination*; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner*. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

(j) The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph 20 of this subsection.

(2) The converted policy shall be issued without evidence of insurability.

(3) The terminated employee or member shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and the employee's or member's dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(A) (i) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program, or

(ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, or

(iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law, and

(B) the benefits provided under the sources referred to in clause (A) (i) above for such person or benefits provided or available under the sources referred to in clauses (A) (ii) and (A) (iii) above for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner of insurance prior to their use in denying coverage.

(7) A converted policy may include a provision whereby the insurer may request information in advance of any premium due date of such policy of any person covered as to whether:

(A) Such person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(B) such person is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(C) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

(8) The converted policy may provide that the insurer may refuse to renew the policy and the coverage of any person insured for the following reasons only:

(A) Either the benefits provided under the sources referred to in clauses (A) (i) and (A) (ii) of paragraph 6 for such person or benefits provided or available under the sources referred to in clause (A) (iii) of paragraph 6 for such person, together with the benefits provided by the converted policy, would result in over-insurance according to the insurer's standards on file with the commissioner of insurance, or the converted policyholder fails to provide the requested information;

(B) fraud or material misrepresentation in applying for any benefits under the converted policy; or

(C) other reasons approved by the commissioner of insurance.

(9) An insurer shall not be required to issue a converted policy which provides coverage and benefits in excess of those provided under the group policy from which conversion is made.

(10) If the converted policy provides that any hospital, surgical or medical benefits payable may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance or the converted policy includes provisions so that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect, the converted policy

shall provide credit for deductibles, copayments and other conditions satisfied under the group policy.

(11) Subject to the provisions and conditions of this act, if the group insurance policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(A) A maximum benefit at least equal to either, at the option of the insurer, paragraphs (i) or (ii) below:

(i) The smaller of the following amounts:

The maximum benefit provided under the group policy or a maximum payment of $250,000 per covered person for all covered medical expenses incurred during the covered person's lifetime.

(ii) The smaller of the following amounts:

The maximum benefit provided under the group policy or a maximum payment of $250,000 for each unrelated injury or sickness.

(B) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000, after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(C) A deductible for each benefit period which, at the option of the insurer, shall be (i) the sum of the benefits deductible and $100, or (ii) the corresponding deductible in the group policy. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to the conditions of paragraph (13), the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such basic benefits.

If the maximum benefit is determined by clause (A)(ii) of this paragraph, the insurer may require that the deductible be satisfied during a period of not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(D) The benefit period shall be each calendar year when the maximum benefit is determined by clause (A)(i) of this paragraph or 24 months when the maximum benefit is determined by clause (A)(ii) of this paragraph.

(E) The term "covered medical expenses," as used above, shall include at least, in the case of hospital room and board charges 80% of the average semiprivate room and board rate for the hospital in which the individual is confined and twice such amount for charges in an intensive care unit. Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and must provide at least a $1,200 maximum benefit.

(12) The conversion privilege required by this act shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in paragraph 11. At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in paragraph (11), provide a policy of comprehensive medical expense benefits without first dollar coverage. The policy shall conform to the requirements of paragraph (11). An insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

(13) The insurer, at its option, may also offer alternative plans for group health conversion in addition to those required by this act.

(14) In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same

conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of employment or membership.

(15) The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

(16) Subject to the conditions set forth above, the continuation and conversion privileges shall also be available:

(A) To the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation;

(B) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or

(C) to a child solely with respect to such child upon termination of such coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

(18) A notification of the conversion privilege shall be included in each certificate of coverage.

(19) A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

(20) The insurer shall give the employee or member and such employee's or member's covered dependents: (A) Reasonable notice of the right to convert at least once during the six-month continuation period; or (B) for persons covered under 29 U.S.C. 1161 et seq., notice of the right to a conversion policy required by this subsection (d) shall be given at least 30 days prior to the end of the continuation period provided by 29 U.S.C. 1161 et seq. or from the date the employer ceases to provide any similar group health plan to any employee. Such notices shall be provided in accordance with rules and regulations adopted by the commissioner of insurance.

(k) (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.

(l) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

New Sec. 12. (a) The committee on surety bonds and insurance is hereby authorized to negotiate and enter into contracts with qualified insurers and sureties for the purpose of purchasing insurance, surety coverage and similar coverages, including the purchase of insurance, surety coverage and similar coverage for any state agency authorized by law to make such purchase, and the acquisition of consulting and other services necessary therefor. The committee shall advertise for proposals. If the committee receives at least three proposals, the committee shall negotiate with the parties submitting proposals and select the party to negotiate with for the purpose of entering into contracts. If less than three parties submit bids, then the committee shall readvertise for proposals. Upon receiving proposals in response to the second advertisement for proposals, the committee shall negotiate with the parties submitting proposals and

select from those parties submitting proposals, the party to negotiate with for the purpose of entering into contracts regardless of the number of proposals received. The division of purchases shall: (1) Maintain records of the requests for proposals; (2) handle the receipt of proposals; and (3) assist the committee in negotiating procedures and the award of contracts.

(b) The provisions of K.S.A. 75-4317 through 75-4320a, and amendments thereto, shall not apply to meetings of the committee when the committee meets solely for the purpose of discussing and preparing strategies for negotiations for such contracts.

(c) Contracts entered into pursuant to this section, shall not be subject to the provisions of K.S.A. 75-3738 to 75-3740, inclusive, and amendments thereto. Such contracts may be for terms of not more than three years and may be renegotiated and renewed. All such contracts shall be subject to the limits of appropriations made or available therefor and subject to the provisions of appropriations acts relating thereto.

(d) The provisions of this section shall be a complete alternative to other procurement procedures available to the committee pursuant to law.

(e) This section shall take effect on and after July 1, 2004.

Sec. 13. From and after July 1, 2004, K.S.A. 75-4105 is hereby amended to read as follows: 75-4105. ~~All~~ *Except as provided in section 12, and amendments thereto, all* surety bonds and insurance contracts purchased pursuant to this act shall be purchased by the committee in the manner prescribed for the purchase of supplies, materials, equipment or contractual services under K.S.A. 75-3738 to 75-3744, inclusive, and amendments thereto. The director of accounts and reports shall not pay any premium or rate on any surety bond or insurance contract until the purchase of such surety bond or contract shall have been approved by the secretary of the committee. Surety bonds or insurance contracts having a premium or rate in excess of $500 purchased hereunder shall be purchased on sealed bids as provided by law for the purchase of other materials, equipment or contractual services. Where more than one state agency is covered by any bond or insurance contract, the committee shall prorate the cost of premiums or rates on any and all such bonds or contracts, except as provided in K.S.A. 75-4114, and amendments thereto, purchased as charges upon the funds of the state agency wherein any covered state officers or employees are employed or covered property is located or controlled. Such prorated charges shall constitute a lawful charge by the committee upon the funds available to any such state agency and shall be paid by each such state agency to the committee, or to the surety or insurance carrier if the committee requires it, in the manner provided by law for the payment of other obligations of such state agency.

Sec. 14. From and after July 1, 2004, K.S.A. 75-4109 is hereby amended to read as follows: 75-4109. (a) The committee, at least once every three years, shall approve the property and casualty insurance coverages that shall be purchased by each state agency.

(b) The committee shall require that each state agency purchase the insurance coverages prescribed by K.S.A. 74-4703, 74-4705, 74-4707, 75-712e, 75-2728, 76-218, 76-391, 76-394, 76-747 and 76-491, and amendments to these sections, and shall prescribe the terms, conditions and amounts of such coverage giving due regard to the operations and requirements of the agencies involved.

(c) The committee shall, in addition to the coverages specified in subsection (b), designate the insurance coverages to be purchased by each state agency that are deemed by the committee to be necessary to protect the state for property of others that may be in the possession or control of such state agencies.

(d) Such coverages as are specified in subsections (b) and (c) may also include coverages on property of the state that are deemed by the committee to be incidental to the basic coverages herein required, and the committee shall prescribe the terms, conditions and amounts of all insurance coverages purchased pursuant to this section. Property of the state board of regents of any university or college which is referred to in subsection (b) may be self-insured as provided under this act.

(e) No property insurance coverage may be purchased by the committee, except as provided herein *or by section 12, and amendments*

thereto, or specifically required by other Kansas statutes or appropriations.

Sec. 15. From and after July 1, 2004, K.S.A. 2003 Supp. 40-4702 is hereby amended to read as follows: 40-4702. (a) The governor of the state of Kansas shall appoint a ~~cabinet level~~ committee which shall be known as the Kansas business health policy committee*, whose purpose is to explore opportunities and encourage employer participation in health plans developed by the committee for low- and modest-wage employees of small employers*.

(b) The Kansas business health policy committee, hereinafter referred to as the health committee, shall consist of:

(1) The secretary of the department of commerce or the secretary's designee;

(2) the secretary of the department of social and rehabilitation services or the secretary's designee;

(3) the commissioner of insurance or the commissioner's designee;

(4) one member appointed by the president of the senate;

(5) one member appointed by the speaker of the house of representatives;

(6) one member appointed by the minority leader of the senate;

(7) one member appointed by the minority leader of the house of representatives; and

(8) three members at large from the private sector appointed by the governor.

The secretary of each state agency represented on this committee shall provide such staff and other resources as the health committee may require.

(c) (1) The initial meeting of the health committee shall be convened within 60 days after the effective date of this act by the governor at a time and place designated by the governor.

(2) Meetings of the health committee subsequent to its initial meeting shall be held and conducted in accordance with policies and procedures established by the health committee.

(3) Commencing at the time of the initial meeting of the health committee, the powers, authorities, duties and responsibilities conferred and imposed upon the health committee by this act shall be operative and effective.

(d) The health committee shall develop and approve a request for proposals for a qualified entity to serve as the Kansas business health partnership, hereinafter referred to as health partnership, which shall provide a mechanism to combine federal and state subsidies with contributions from small employers and eligible employees to purchase health insurance in accordance with guidelines developed by the health committee.

(e) The health committee shall evaluate responses to the request for proposals and select the qualified entity to serve as the health partnership.

(f) The health committee shall:

(1) Develop, approve and revise subsidy eligibility criteria provided that:

(A) Low wage and modest wage employees of small employers shall be eligible for subsidies if:

~~(1)~~ *(i)* The small employer has not previously offered health insurance coverage *within the two years next preceding the date upon which health insurance is offered*; or

~~(2)~~ *(ii)* the small employer has previously offered health insurance coverage and a majority of such small employer's employees are low wage or modest wage employees as defined in K.S.A. 40-4701, and amendments thereto;

(B) any small employer's eligible employee with a child who is eligible for coverage under the state childrens' health insurance program established by K.S.A. 38-2001 *et seq.*, and amendments thereto, or in the state medical assistance program shall be eligible automatically for a subsidy and shall be included in the determination of eligibility for the small employer and its low-and-modest wage employees; and

(C) at least 70% of the small employer's eligible employees without group health insurance coverage from another source are insured through the partnership; and

(2) determine and arrange for eligibility determination for subsidies of low wage or modest wage employees; and

(3) develop subsidy schedules based upon eligible employee wage levels and family income~~;~~ *; and*

(4) be responsible for arranging for the provision of affordable health care coverage for eligible employees of small employers and evaluating and creating the opportunity to improve health care provided by plans in the small group health insurance program.

(g) The health committee shall oversee and monitor the ongoing operation of any subsidy program and the financial accountability of all subsidy funds. If, in the judgment of the health committee, the entity selected to serve as the health partnership fails to perform as intended, the health committee may terminate its selection and designation of that entity as the health partnership and may issue a new request for proposal and select a different qualified entity to serve as the health partnership.

(h) The health committee is hereby authorized to accept funds from the federal government, or its agencies, or any other source whatsoever for research studies, investigation, planning and other purposes related to implementation of the objectives of this act. Any funds so received shall be deposited in the state treasury and shall be credited to a special revenue fund which is hereby created and shall be known as the health committee insurance fund and used in accordance with or direction of the contributing federal agencies. Expenditures from such fund may be made for any purpose in keeping with the responsibilities, functions and authority of the department. Warrants on such fund shall be drawn in the same manner as required of other state agencies upon vouchers signed by the secretary of the department of social and rehabilitation services upon receiving prior approval of the health committee.

(i) The health committee is authorized to develop policies for the administration of the subsidy program and for the use of additional federal or private funds to subsidize health insurance coverage for low-and-modest wage employees of predominantly low-wage small employers. *The health committee shall be responsible for setting benefit levels and establishing performance measures for health plans providing health care coverage for this program that include quality, preventative health and other supplementary measures. The health committee shall limit access to the program subsidy to the projected annualized expenditure.*

(j) The health committee is hereby authorized to organize, or cause to be organized, one or more advisory committees. No member of any advisory committee established under this subsection shall have previously received or currently receive any payment or other compensation from the health partnership. The membership of each advisory committee established under this subsection shall contain at least one representative who is a small employer and one representative who is an eligible employee as defined in K.S.A. 40-4701, and amendments thereto, and one representative of the insurance industry.

(k) The health committee shall report on an annual basis on the following subjects:

(1) Quality assurance measures;

(2) disease prevention activities;

(3) disease management activities; and

(4) other activities or programs the committee decides to include.

Sec. 16. From and after July 1, 2004, K.S.A. 2003 Supp. 40-4704 is hereby amended to read as follows: 40-4704. The health partnership shall develop and offer two or more health benefit plans to small employers. In any health benefit plan developed under this act, any carrier may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. Except for preventative and health screening services, the provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2114 and subsection (i) of 40-2209 and 40-2229 and 40-2230, and 40-2,163, 40-2,164, 40-2,165 and 40-2,166, and amendments thereto, shall not be mandatory with respect to any health benefit plan developed under this act. In performing these duties, the health partnership shall:

(a) Develop and offer two or more lower-cost benefit plans such that:

(1) Each health benefit plan is consistent with any criteria established by the health partnership;

(2) each health benefit plan shall be offered by all participating carriers except that no participating carrier shall be required to offer any health benefit plan, or portion thereof, which such participating carrier is not licensed or authorized to offer in this state;

(3) no participating carrier shall offer any health benefit plan developed under this act to any small employer unless such small employer is covered through the health partnership.

(b) Develop and make available one or more supplemental health benefit plans or one or more other benefit options so that the total package of health benefits available to all children eligible for the state children's health insurance program established pursuant to K.S.A. 68-2001 *et seq.*, and amendments thereto, meets, at a minimum, standards established by the federal health insurance program.

(c) Offer coverage to any qualifying small employer.

(d) Offer eligible employees of participating small employers a choice of participating carriers where feasible.

(e) (1) Include centralized and consolidated enrollment, billing and customer service functions;

(2) use one standard enrollment form for all participating carriers; and

(3) submit one consolidated bill to the small employer.

(f) Issue or cause to be issued a request for proposals and contract with a qualified vendor for any administrative or other service not performed by the health committee or provided to the health committee under subsection (b) of K.S.A. 40-4702, and amendments thereto.

(g) Issue a request for proposals and selectively contract with carriers.

(h) Establish conditions of participation for small employers that conform with K.S.A. 40-2209b *et seq.*, and amendments thereto, and the health insurance portability and accountability act of 1996 (Public Law 104-191).

(i) Enroll small employers and their eligible employees and dependents in health benefit plans developed under this act.

(j) Bill and collect premiums from participating small employers including any share of the premium paid by such small employer's enrolled employees.

(k) Remit funds collected under subsection (h) to the appropriate contracted carriers.

(l) Provide that each low-or-modest wage employee shall be permitted to enroll in such employee's choice of participating carrier where available.

(m) Develop premium rating policies for small employers.

(1) In consultation with the health committee, the health partnership shall ensure, to the maximum extent possible, that the combined effect of the premium rating and subsidy policies is that subsidized eligible employees and the dependents of such subsidized eligible employees can afford coverage.

(2) Any rating policy developed under this subsection may vary with respect to subsidy status of eligible employees and the dependents of such eligible employees.

(n) Be authorized to contract for additional group vision, dental and life insurance plans, and other limited insurance products.

(o) Take whatever action is necessary to assure that any eligible employee or dependent of such eligible employee who receives health benefit coverage through the health partnership and who is eligible for the state medical assistance program shall remain eligible to participate in the state health insurance premium payment program.

(p) Coordinate with the department of social and rehabilitation services to assure that any funds available for the coverage of infants and pregnant women under the state medical assistance program are also available for the benefit of eligible infants and pregnant women who receive health benefit coverage through the health partnership as an eligible employee or dependent of such eligible employee.

(q) Work with the department of social and rehabilitation services office of medical policy and medicaid to develop a single employee application that may be used by the health plan and the medicaid and state children's health insurance program to determine eligibility.

(r) Screen employee applications for subsidy eligibility and dependent

children for medicaid and state children's health insurance program premium support eligibility.

Sec. 17. From and after July 1, 2004, K.S.A. 2003 Supp. 40-4706 is hereby amended to read as follows: 40-4706. The department of social and rehabilitation services shall investigate and pursue all possible policy options to bring into this partnership title XIX and the title XXI eligible families of any eligible employees employed by a small employer. Further, the department of social and rehabilitation services shall develop and seek federal approval of any appropriate variance or state plan amendment for the state children's health insurance program established by K.S.A. 38-2001 *et seq.*, and amendments thereto, and the state medical assistance program required to accomplish the purposes of this act. *The department of social and rehabilitation services office of medical policy and medicaid shall work with the health partnership to develop a single employee application that may be used by the health plan and the medicaid and state children's health insurance program to determine eligibility.*

Sec. 18. On and after January 1, 2005, K.S.A. 2003 Supp. 40-2404, as amended by section 6 of this act, is hereby further amended to read as follows: 40-2404. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies.* Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison which:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, which is untrue, deceptive or misleading.

(3) *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(4) *Boycott, coercion and intimidation.* Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) *False statements and entries.* (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the pub-

lic, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.

(7) *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(d) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for accident and health and life insurance to an applicant who is the proposed insured or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse, except as provided in subpart (v). "Abuse" as used in this subsection (7)(d) means one or more acts defined in subsection (a) or (b) of K.S.A. 60-3102 and amendments thereto between family members, current or former household members, or current or former intimate partners.

(i) An insurer may not ask an applicant for life or accident and health insurance who is the proposed insured if the individual is, has been or may be the subject of domestic abuse or seeks, has sought or had reason to seek medical or psychological treatment or counseling specifically for abuse, protection from abuse or shelter from abuse.

(ii) Nothing in this section shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is, has been or has the potential to be the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy.

(iii) No insurer that issues a life or accident and health policy to an individual who is, has been or may be the subject of domestic abuse shall be subject to civil or criminal liability for the death or any injuries suffered by that individual as a result of domestic abuse.

(iv) No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical

or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles.

(v) Nothing in this section shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition has been caused by abuse, provided that:

(A) The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse;

(B) the fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and

(C) such underwriting or rating is not used to evade the intent of this section or any other provision of the Kansas insurance code.

(vi) Any person who underwrites or rates a risk on the basis of preexisting physical or mental condition as set forth in subsection (7)(d)(v), shall treat such underwriting or rating as an adverse underwriting decision pursuant to K.S.A. 40-2,112, and amendments thereto.

(vii) The provisions of subsection (d) shall apply to all policies of life and accident and health insurance issued in this state after the effective date of this act and all existing contracts which are renewed on or after the effective date of this act.

(8) *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; or

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are: (A) Committed flagrantly and in conscious disregard of such provisions, or (B) committed with such frequency as to indicate a general business practice.

(a) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *Failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints which it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) *Misrepresentation in insurance applications.* Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) *Statutory violations.* Any violation of any of the provisions of K.S.A. 40-216, 40-276a, 40-2,155 or 40-1515 and amendments thereto.

(13) *Disclosure of information relating to adverse underwriting decisions and refund of premiums.* Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the time prescribed in such section.

(14) *Rebates and other inducements in title insurance.* (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may

knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in (14)(a).

(c) Nothing in this section shall be construed as prohibiting:

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

(e) As used in paragraphs (e) through (i)(7) of this subpart, unless the context otherwise requires:

(i) "Associate" means any firm, association, organization, partnership, business trust, corporation or other legal entity organized for profit in which a producer of title business is a director, officer or partner thereof, or owner of a financial interest; the spouse or any relative within the second degree by blood or marriage of a producer of title business who is a natural person; any director, officer or employee of a producer of title business or associate; any legal entity that controls, is controlled by, or is under common control with a producer of title business or associate; and any natural person or legal entity with whom a producer of title business or associate has any agreement, arrangement or understanding or pursues any course of conduct, the purpose or effect of which is to evade the provisions of this section.

(ii) "Financial interest" means any direct or indirect interest, legal or beneficial, where the holder thereof is or will be entitled to 1% or more of the net profits or net worth of the entity in which such interest is held. Notwithstanding the foregoing, an interest of less than 1% or any other type of interest shall constitute a "financial interest" if the primary purpose of the acquisition or retention of that interest is the financial benefit to be obtained as a consequence of that interest from the referral of title business.

(iii) "Person" means any natural person, partnership, association, cooperative, corporation, trust or other legal entity.

(iv) "Producer of title business" or "producer" means any person, including any officer, director or owner of 5% or more of the equity or capital or both of any person, engaged in this state in the trade, business, occupation or profession of:

(A) Buying or selling interests in real property;

(B) making loans secured by interests in real property; or

(C) acting as broker, agent, representative or attorney for a person who buys or sells any interest in real property or who lends or borrows money with such interest as security.

(v) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

~~(e)~~ *(f)* No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.

~~(f)~~ *(g)* No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent, and (ii) ~~20%~~ *70%* or more of the ~~gross operating revenue~~ *closed title orders*

of that title insurer or title agent during the ~~six~~ *12* full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this subparagraph shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.

(h) Within 90 days following the end of each business year, as established by the title insurer or title agent, each title insurer or title agent shall file with the department of insurance and any title insurer with which the title agent maintains an underwriting agreement, a report executed by the title insurer's or title agent's chief executive officer or designee, under penalty of perjury, stating the percent of closed title orders originating from controlled business. The failure of a title insurer or title agent to comply with the requirements of this section, at the discretion of the commissioner, shall be grounds for the suspension or revocation of a license or other disciplinary action, with the commissioner able to mitigate any such disciplinary action if the title insurer or title agent is found to be in substantial compliance with competitive behavior as defined by federal housing and urban development statement of policy 1996-2.

(i) (1) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person if it knows or has reason to believe that such person was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed in writing to the person so referred the fact that such producer or associate has a financial interest in the title insurer or title agent, the nature of the financial interest and a written estimate of the charge or range of charges generally made by the title insurer or agent for the title services. Such disclosure shall include language stating that the consumer is not obligated to use the title insurer or agent in which the referring producer or associate has a financial interest and shall include the names and telephone numbers of not less than three other title insurers or agents which operate in the county in which the property is located. If fewer than three insurers or agents operate in that county, the disclosure shall include all title insurers or agents operating in that county. Such written disclosure shall be signed by the person so referred and must have occurred prior to any commitment having been made to such title insurer or agent.

(2) No producer of title business or associate of such producer shall require, directly or indirectly, as a condition to selling or furnishing any other person any loan or extension thereof, credit, sale, property, contract, lease or service, that such other person shall purchase title insurance of any kind through any title agent or title insurer if such producer has a financial interest in such title agent or title insurer.

(3) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person it knows or has reason to believe that the name of the title company was pre-printed in the sales contract, prior to the buyer or seller selecting that title company.

(4) Nothing in this subpart (i) shall prohibit any producer of title business or associate of such producer from referring title business to any title insurer or title agent of such producer's or associate's choice, and, if such producer or associate of such producer has any financial interest in the title insurer, from receiving income, profits or dividends produced or realized from such financial interest, so long as:

(a) Such financial interest is disclosed to the purchaser of the title insurance in accordance with part (i)(1) through (4) of this subpart;

(b) the payment of income, profits or dividends is not in exchange for the referral of business; and

(c) the receipt of income, profits or dividends constitutes only a return on the investment of the producer or associate.

(5) Any producer of title business or associate of such producer who violates the provisions of paragraphs (i)(2) through (i)(4), or any title insurer or title agent who accepts an order for title insurance knowing that it is in violation of paragraphs (i)(2) through (i)(4), in addition to any other action which may be taken by the commissioner of insurance, shall be subject to a fine by the commissioner in an amount equal to five times the premium for the title insurance and, if licensed pursuant to K.S.A. 58-3034 et seq., and amendments thereto, shall be deemed to have

committed a prohibited act pursuant to K.S.A. 58-3602, and amendments thereto, and shall be liable to the purchaser of such title insurance in an amount equal to the premium for the title insurance.

(6) Any title insurer or title agent that is a competitor of any title insurer or title agent that, subsequent to the effective date of this act, has violated or is violating the provisions of subpart (i), shall have a cause of action against such title insurer or title agent and, upon establishing the existence of a violation of any such provision, shall be entitled, in addition to any other damages or remedies provided by law, to such equitable or injunctive relief as the court deems proper. In any such action under this subsection, the court may award to the successful party the court costs of the action together with reasonable attorney fees.

(7) The commissioner shall also require each title agent to provide core title services as required by the real estate settlement procedures act.

~~(g)~~ *(j)* The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* (a) No person shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this section. Such rules and regulations shall be consistent with and not more restrictive than the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation".

(b) Any rules and regulations adopted by the commissioner which implement article V of the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation" shall become effective on and after February 1, 2002.

(c) Nothing in this paragraph (15) shall be deemed or construed to authorize the promulgation or adoption of any regulation which preempts, supersedes or is inconsistent with any provision of Kansas law concerning requirements for notification of, or obtaining consent from, a parent, guardian or other legal custodian of a minor relating to any matter pertaining to the health and medical treatment for such minor.

Sec. 19. K.S.A. 40-241, 40-246b, 40-246f, 40-2,131, 40-2118, 40-2122, 40-2124 and 40-4503 are hereby repealed.

Sec. 20. From and after July 1, 2004, K.S.A. 40-216, 40-2209, 75-4105 and 75-4109 and K.S.A. 2003 Supp. 40-2c01, 40-2404, 40-4702, 40-4704 and 40-4706 are hereby repealed.

Sec. 21. From and after January 1, 2005, K.S.A. 2003 Supp. 40-2404, as amended by section 6 of this act, and K.S.A. 2003 Supp. 40-2404, as amended by section 1 of 2004 Senate Bill No. 66, are hereby repealed.

Sec. 22. This act shall take effect and be in force from and after its publication in the Kansas register.

I hereby certify that the above BILL originated in the HOUSE, and passed that body

_____

HOUSE adopted
Conference Committee Report _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report _____

_____
President of the Senate.

_____
Secretary of the Senate.

APPROVED _____

_____
Governor.