

HOUSE BILL No. 2819

By Committee on Health and Human Services

2-11

9 AN ACT enacting the adult care home group-funded pool act; author-
10 izing adult care homes to pool liabilities; providing certificate of au-
11 uthority to operate pools and providing for the regulation thereof;
12 amending K.S.A. 40-2121, 40-2209, 40-2209f, 40-2259, 40-3606, 44-
13 559a and 65-474 and repealing the existing sections.
14

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

16 New Section 1. (a) Sections 1 through 14 and amendments thereto
17 shall be known and may be cited as the adult care home group-funded
18 pool act.

19 (b) The provisions of K.S.A. 40-2209 and 40-2215 and amendments
20 thereto shall apply to group-funded pools and all contracts issued under
21 this act.

22 New Sec. 2. Five or more adult care homes which are members of
23 the same bona fide trade association may enter into agreements to pool
24 their liabilities for Kansas fire, marine, inland marine and allied lines, as
25 defined in K.S.A. 40-901, and amendments thereto, casualty, surety and
26 fidelity lines as defined in K.S.A. 40-1102, and amendments thereto, in-
27 cluding workers' compensation and employers' liability, group sickness
28 and accidents, as defined in K.S.A. 40-2209, and amendments thereto,
29 and life insurance, as regulated in K.S.A. 40-433, and amendments
30 thereto. Such arrangements shall be known as group-funded pools, which
31 shall not be deemed to be insurance or insurance companies and shall
32 not be subject to the provisions of chapter 40 of the Kansas Statutes
33 Annotated, except as otherwise provided herein.

34 New Sec. 3. Application for a certificate of authority to operate a
35 pool shall be made to the commissioner of insurance not less than 30
36 days prior to the proposed inception date of the pool. The application
37 shall include the following:

38 (a) A copy of the bylaws of the proposed pool, a copy of the articles
39 of incorporation, if any, and a copy of all agreements and rules of the
40 proposed pool. If any of the bylaws, articles of incorporation, agreements
41 or rules are changed, the pool shall notify the commissioner within 30
42 days after such change.

43 (b) Designation of the initial board of trustees and administrator.

1 When there is a change in the membership of the board of trustees or
2 change of administrator, the pool shall notify the commissioner within 30
3 days after such change.

4 (c) The address where the books and records of the pool will be
5 maintained at all times. If this address is changed, the pool shall notify
6 the commissioner within 30 days after such change.

7 (d) Evidence that the annual Kansas gross premium of the pool will
8 be not less than \$250,000 for each of the categories described in subpar-
9 agraphs (1) through (4) of this subsection: (1) All property insurance under
10 article 9 of chapter 40 of the Kansas Statutes Annotated except motor
11 vehicle physical damage; (2) motor vehicle liability and physical damage
12 insurance; (3) workers' compensation and employers' liability insurance;
13 (4) all casualty insurance under article 11 of chapter 40 of the Kansas
14 Statutes Annotated except insurance under categories (2) and (3) above;
15 (5) group sickness and accident insurance if at the date of issue the annual
16 gross premium for such coverage will be not less than \$1,000,000; and
17 (6) group life insurance if at the date of issue the coverage will insure at
18 least 60% of the eligible participants or the total number of persons covered
19 will exceed 600. The pool shall notify the commissioner within 30
20 days if the minimum premium qualification or participation requirement
21 is less than that specified in this subsection for any of the above categories
22 of insurance. The pool may offer coverage in any one or combination of
23 the above insurance categories.

24 (e) An agreement binding the group and each member thereof to
25 comply with the provisions of the workers compensation act if such cover-
26 age is to be provided by the pool. For all lines of coverage, all members
27 of the pool shall be jointly liable for the payment of claims to the extent
28 of the assets of the pool.

29 (f) A copy of the procedures adopted by the pool to provide services
30 with respect to underwriting matters and, with respect to the categories
31 identified in subsection (d)(1) through (4), safety engineering.

32 (g) A copy of the procedures adopted by the pool to provide claims
33 adjusting and accumulation of income and expense and loss data.

34 (h) A confirmation that specific excess insurance provided by an in-
35 surance company is or will be in effect concurrent with the assumption
36 of risk by the pool, as selected by the board of trustees of the pool, or
37 adequate surplus funds as approved by the commissioner, in the pool.
38 The pool shall notify the commissioner within 30 days of any change in
39 the specific excess insurance carried by the pool. For the purposes hereof,
40 "surplus funds" shall mean retained earnings of the pool after reserves
41 have been established for all known and incurred but not reported losses
42 of the pool and after all other liabilities of the pool, including unearned
43 premium reserves, have been deducted from total assets. The term "ad-

1 equate surplus funds” shall mean the amount necessary for the pool to
2 fund its self-insured obligations.

3 (i) After evaluating the application the commissioner shall notify the
4 applicant if the plan submitted is inadequate, fully explaining to the ap-
5 plicant what additional requirements must be met. If the application is
6 denied, the applicant shall have 10 days to make an application for hearing
7 by the commissioner after the denial notice is received. A record shall be
8 made of such hearing, and the cost thereof shall be assessed against the
9 applicant requesting the hearing.

10 (j) Any other relevant factors the commissioner may deem necessary.

11 New Sec. 4. Every group-funded pool applying for authority to op-
12 erate a pool in this state, as a condition precedent to obtaining such au-
13 thority, shall file in the insurance department a written irrevocable con-
14 sent, that any action may be commenced against such pool in the proper
15 court of any county in this state in which the cause of action shall arise
16 or in which the plaintiff may reside by the service of process on the
17 commissioner of insurance of this state, and stipulating and agreeing that
18 such service shall be taken and held in all courts to be as valid and binding
19 as if due service had been made upon the trustees or the administrator
20 of such pool. The consent shall be executed by the board of trustees and
21 shall be accompanied by a duly certified copy of the resolution passed by
22 the trustees to execute such consent.

23 New Sec. 5. (a) All certificates granted hereunder shall be perpetual
24 unless sooner suspended or revoked by the commissioner or the attorney
25 general.

26 (b) Whenever the commissioner shall deem it necessary the com-
27 missioner may make, or direct to be made, an examination of the affairs
28 and the financial condition of any pool, except that once every five years
29 the commissioner shall conduct an examination of the affairs and the
30 financial condition of each pool. Each pool shall submit a certified inde-
31 pendent audited financial statement no later than 90 days after the end
32 of the fiscal year. The financial statement shall include outstanding re-
33 serves for claims and for claims incurred but not reported. Each pool
34 shall file reports as to income, expenses and loss data at such times and
35 in such manner as the commissioner shall require. Any pool which does
36 not use rates developed by an approved rating organization shall file with
37 the commissioner an actuarial certification that such rates are actuarially
38 sound. Whenever it appears to the commissioner from such examination
39 or other satisfactory evidence that the ability to pay current and future
40 claims of any such pool is impaired, or that it is doing business in violation
41 of any of the laws of this state, or that its affairs are in an unsound con-
42 dition so as to endanger its ability to pay or cause to be paid claims in the
43 amount, manner and time due, the commissioner shall, before filing such

1 report or making the same public, grant such pool upon reasonable notice
2 a hearing, and, if on such hearing the report be confirmed, the commis-
3 sioner may require any of the actions allowed under K.S.A. 40-222b and
4 amendments thereto or suspend the certificate of authority for such pool
5 until its ability to pay current and future claims shall have been fully
6 restored and the laws of the state fully complied with. The commissioner
7 may, if there is an unreasonable delay in restoring the ability to pay claims
8 of such pool and in complying with the law or if rehabilitation or correc-
9 tive action taken under K.S.A. 40-222b and amendments thereto is un-
10 successful, revoke the certificate of authority of such pool to do business
11 in this state. Upon revoking any such certificate the commissioner shall
12 communicate the fact to the attorney general, whose duty it shall be to
13 commence and prosecute an action in the proper court to dissolve such
14 pool or to enjoin the same from doing or transacting business in this state.
15 The commissioner of insurance may call a hearing under K.S.A. 40-222b,
16 and amendments thereto, and the provisions thereof shall apply to group-
17 funded pools.

18 (c) On an annual basis, or within 30 days of any change thereto, each
19 pool shall supply to the commissioner the name and qualifications of the
20 designated administrator of the pools and the terms of the specific and
21 aggregate excess insurance contracts of the pool.

22 New Sec. 6. (a) With respect to the categories of coverage described
23 in subparagraphs (d)(1) through (4) of section 3, and amendments
24 thereto, premium contributions to the pool shall be based upon appro-
25 priate manual classification and rates, plus or minus applicable experience
26 credits or debits, and minus any advance discount approved by the trust-
27 ees, not to exceed 25% of manual premium. The pool shall use rules,
28 classifications and rates as promulgated by an approved rating organiza-
29 tion for workers compensation. Premium contributions to the pool for all
30 other lines of insurance shall be based on rates filed by a licensed rating
31 organization or on rates of certain companies filing rates with the com-
32 missioner and approved by the commissioner for the pool. In lieu of the
33 foregoing, the board of trustees may determine such classification, rates
34 and discounts as approved by the commissioner.

35 Premium contributions to any pool providing life insurance or any pool
36 providing group sickness and accident insurance as described in section
37 2, and amendments thereto, shall be based on sound actuarial principles.

38 (b) Any moneys for a fund year in excess of the amount necessary to
39 fulfill all obligations of the pool for that fund year, including any obligation
40 to retain adequate surplus funds, as defined by subsection (h) of section
41 3, and amendments thereto, in lieu of specific and aggregate excess in-
42 surance, may be declared to be refundable by the trustees not less than
43 12 months after the end of the fund year. Any such refund shall be paid

1 only to those members who remained participants in the pool for an entire
2 year. Payment of previously earned refunds shall not be contingent on
3 continued membership in the pool.

4 New Sec. 7. The trustees shall not utilize any of the contributions
5 collected as premiums for any purpose unrelated to the pool. Moneys not
6 needed for current obligations may be invested by the trustees. Such
7 investments are permitted in any securities or other investments permit-
8 ted by article 2 of chapter 40 of the Kansas Statutes Annotated and acts
9 amendatory thereof or supplemental thereto.

10 New Sec. 8. The expense of state supervision of the group-funded
11 pools shall be financed in the following manner:

12 (a) There is hereby created in the state treasury a fund to be called
13 the group-funded pools fee fund. All amounts which are required to be
14 paid from the group-funded pools fee fund for the operating expenditures
15 incident to the supervision of the group-funded pools shall be paid from
16 the group-funded pools fee fund. The commissioner of insurance shall
17 be responsible for administering the group-funded pools fee fund and all
18 payments from the fund shall be upon warrants of the director of accounts
19 and reports issued pursuant to vouchers approved by the commissioner
20 of insurance or a person or persons designated by the commissioner.

21 (b) The commissioner of insurance shall estimate as soon as practical
22 after January 1 of each year the expenses necessary for the supervision of
23 the group-funded pools for the fiscal year beginning on July 1 thereafter.
24 Not later than June 1 of each year, the commissioner of insurance shall
25 notify all such group-funded pools of the amount of each assessment
26 imposed under this subsection on such group-funded pools and the same
27 shall be due and payable to the commissioner on the July 1 following.

28 (c) The commissioner of insurance shall remit all moneys received by
29 or for such remittance to the state treasurer in accordance with the pro-
30 visions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each
31 such remittance, the state treasurer shall deposit the entire amount in the
32 state treasury to the credit of the group-funded pools fee fund.

33 New Sec. 9. In addition to any fees required to be paid under this
34 act, and as a condition precedent to the continuation of the certificate of
35 authority provided in this act, all group-funded pools shall pay no later
36 than 90 days after the end of each fiscal year a tax upon the annual Kansas
37 gross premium collected by the pool at the rate of 1% per annum applied
38 to the collective premium relating to all Kansas members of the pool for
39 the preceding fiscal year. In the computation of the tax, all pools shall be
40 entitled to deduct any annual Kansas gross premiums returned on account
41 of cancellation or dividends returned to members of such pools or ex-
42 penditures used for the purchase of specific and aggregate excess insur-
43 ance, as provided in subsection (h) of section 3 and amendments thereto.

1 New Sec. 10. (a) Each pool shall be assessed annually as provided by
2 K.S.A. 44-566a and 74-713, and amendments thereto.

3 (b) Each proposed and authorized pool and each person representing
4 such proposed or authorized pool shall be subject to the provisions of
5 article 24 of chapter 40 of the Kansas Statutes Annotated.

6 (c) Each pool shall be subject to the provisions of K.S.A. 40-246b to
7 40-246e, inclusive, and amendments thereto.

8 (d) Whenever a pool is available providing workers compensation
9 coverage to a statewide group of adult care homes, the premium on work-
10 ers compensation coverage written on adult care homes eligible to be-
11 come members of such pool by an insurer shall not be considered in the
12 determination of any assessments levied by the Kansas workers compen-
13 sation plan established pursuant to K.S.A. 40-2109 and amendments
14 thereto.

15 New Sec. 11. (a) After the inception date of the group-funded pool,
16 prospective new members of the pool shall submit an application for
17 membership to the board of trustees or its administrator. The trustees
18 may approve the application for membership pursuant to the bylaws of
19 the pool.

20 (b) Before the time that membership in a group funded pool is
21 granted, the applicant for such membership shall be provided a written
22 notice stating that: (1) The group funded pool is not an insurance com-
23 pany subject to the general laws and rules and regulations relating to
24 insurance companies; and (2) the group funded pool is subject to separate
25 regulation by the Kansas insurance department as authorized by state
26 statute and cannot commence or continue operations without a certificate
27 of authority. Such authorization does not constitute an endorsement or
28 recommendation of the coverage provided.

29 (c) Individual members may elect to terminate their participation in
30 a pool or be subject to cancellation by the pool pursuant to the bylaws of
31 the pool. On termination or cancellation of a workers' compensation
32 member, the pool shall notify the division of workers' compensation
33 within 10 days and shall maintain coverage of each cancelled or termi-
34 nating member for 30 days after notice to such division or until such
35 division gives notice that the cancelled or terminating member has pro-
36 cured workers' compensation and employers' liability insurance, which-
37 ever occurs first.

38 New Sec. 12. To ensure the financial stability of the operations of
39 each group-funded pool, the board of trustees of each pool is responsible
40 for all operations of the pool. The board of trustees shall consist of not
41 less than three persons selected according to the bylaws of the pool for
42 stated terms of office to direct the administration of a pool, and whose
43 duties include approving applications by new members of the pool. The

1 majority of the trustees must be a member of the governing body or an
2 officer or employee of members of the pool, but a trustee may not be an
3 owner, officer or employee of any service agent or representative. All
4 trustees shall be residents of this state. The board of trustees of each fund
5 shall take all necessary precautions to safeguard the assets of the fund,
6 including all of the following:

7 (a) Designate an administrator to administer the financial affairs of
8 the pool who shall furnish a fidelity bond to the pool in an amount de-
9 termined by the trustees to protect the pool against the misappropriation
10 or misuse of any moneys or securities. The administrator shall file evi-
11 dence of the bond with the commissioner. The bond shall be one of the
12 conditions required for approval of the establishment and continued op-
13 eration of a pool. Any administrator so designated shall be a resident of
14 Kansas if an individual or shall be authorized to do business in Kansas if
15 a corporation.

16 (b) Retain control of all moneys collected or disbursed from the pool.
17 The trustees may establish a revolving fund for use by the authorized
18 service agent which is replenished from time to time. The service agent
19 and its employees shall be covered by a fidelity bond, with the pool as
20 obligee, in an amount sufficient to protect all moneys placed in the re-
21 volving fund.

22 (c) Audit the accounts and records of the pool annually or at any time
23 as required. The commissioner shall prescribe the type of audits and a
24 uniform accounting system for use by pool and service agents to deter-
25 mine the ability of the pool to pay current and future claims.

26 (d) The trustees shall not extend credit to individual members for any
27 purpose.

28 (e) The board of trustees shall not borrow any moneys from the pool
29 or in the name of the pool without advising the commissioner of the
30 nature and purpose of the loan.

31 (f) The board of trustees may delegate authority for specific functions
32 to the administrator of the pool. The functions which the board may
33 delegate include such matters as contracting with a service agent, deter-
34 mining the premium chargeable to and refunds payable to members,
35 investing surplus moneys and approving applications for membership.
36 The board of trustees shall specifically define all authority it delegates in
37 the written minutes of the trustees' meetings. Any delegation of authority
38 shall not be effective without a formal resolution passed by the trustees.

39 New Sec. 13. Any person or agency soliciting for a proposed or au-
40 thorized group-funded pool shall hold a current license authorizing such
41 person to sell each line of insurance offered for sale. Any person licensed
42 for the kinds of insurance offered by the pool shall be deemed to be
43 certified by a company for the kinds of insurance permitted by the pool.

1 New Sec. 14. The commissioner of insurance shall make such rec-
2 ommendations as deemed advisable to assist in the effective, efficient and
3 fiscally sound operation of any proposed group-funded pool. Within the
4 time and resources available, the department of insurance shall provide
5 advice and counsel to any group-funded pool.

6 Sec. 15. K.S.A. 40-2121 is hereby amended to read as follows: 40-
7 2121. (a) Following the close of each fiscal year, the administering carrier
8 shall determine the net premiums, the plan expenses of administration
9 and the incurred losses for the year. Any net loss of the plan determined
10 after taking into account amounts transferred pursuant to subsection (h)
11 of K.S.A. 79-4804, and amendments thereto, investment income and
12 other appropriate gains and losses shall be assessed by the board to all
13 members of the association in proportion to their respective shares of
14 total health insurance premiums received in this state during the calendar
15 year coinciding with or ending during the fiscal year of the association or
16 any other equitable basis as may be provided in the plan of operation.
17 For health maintenance organization members and insurance arrange-
18 ments, the proportionate share of losses shall be determined through
19 application of an equitable formula based upon claims paid on the value
20 of services provided. In sharing losses, the board may abate or defer in
21 whole or in part the assessment of a member if, in the opinion of the
22 board, payment of the assessment would endanger the ability of the mem-
23 ber to fulfill its contractual obligations. Health insurance benefits paid by
24 an insurance arrangement that are less than an amount determined by
25 the board to justify the cost of collection shall not be considered for
26 purposes of determining assessments. Net gains, if any, shall be held at
27 interest to offset future losses or allocated to reduce future premiums. In
28 addition to any annual assessment at the close of the fiscal year of the
29 plan authorized by this subsection, the board may provide for interim
30 assessments of the members of the association, subject to the approval of
31 the commissioner, as may be necessary to assure the financial capability
32 of the association in meeting the incurred or estimated claims expenses
33 of the plan and the operating and administrative expenses of the plan.

34 (b) In addition to any assessment authorized by subsection (a), the
35 board may assess the members of the association for any initial costs
36 associated with developing and implementing the plan to the extent such
37 costs exceed the funds transferred to the uninsurable health insurance
38 plan fund pursuant to K.S.A. 40-2125 and amendments thereto. Such
39 assessment shall be allocated among the members of the association in
40 the manner prescribed by subsection (a) of this section or any other eq-
41 uitable formula established by the board. Assessments under this subsec-
42 tion shall not be subject to the credit against premium tax under subsec-
43 tion (c).

1 (c) For taxable years commencing after December 31, 1995, and
2 prior to January 1, 1998, 80% of any assessment made against a member
3 of the association pursuant to subsection (a) of this section may be claimed
4 by such member as a credit against such member's premium or privilege
5 tax liability imposed by K.S.A. 12-2624, 40-252 or 40-3213 and amend-
6 ments thereto, for the taxable year in which such assessment is paid. For
7 the tax year commencing after December 31, 1997, 70% of any assess-
8 ment made against a member of the association pursuant to subsection
9 (a) of this section may be claimed by such member as a credit against
10 such member's premium tax liability imposed by K.S.A. 12-2624, 40-252
11 or 40-3213 and amendments thereto, for the taxable year in which such
12 assessment is paid.

13 For the tax year commencing after December 31, 1998, 65% of any
14 assessment made against a member of the association pursuant to sub-
15 section (a) of this section may be claimed by such member as a credit
16 against such member's premium tax liability imposed by K.S.A. 12-2624,
17 40-252 or 40-3213 and amendments thereto, for the taxable year in which
18 such assessment is paid.

19 For the tax year commencing after December 31, 1999, 60% of any
20 assessment made against a member of the association pursuant to sub-
21 section (a) of this section may be claimed by such member as a credit
22 against such member's premium tax liability imposed by K.S.A. 12-2624,
23 *section 9*, 40-252 or 40-3213 and amendments thereto, for the taxable
24 year in which such assessment is paid.

25 (d) In addition to the assessments otherwise authorized herein, the
26 board shall assess all issuers of medicare supplement policies covering
27 persons within this state to the extent necessary to assure that the excess
28 losses, if any, are distributed among such issuers of medicare supplement
29 policies in a ratio equal to the percentage market share in Kansas of each
30 such issuer for medicare supplement policies covering persons eligible
31 for medicare by reason of age. The association shall also assess to such
32 issuers of medicare supplement policies the costs the association incurs
33 in operating the reinsurance program, making assessments, and collecting
34 and distributing moneys, which shall be assessed pro rata to such issuers
35 based on the market share of such issuers of medicare supplement poli-
36 cies covering persons eligible for medicare by reason of age. Such as-
37 sessment shall occur not later than July 1 of each year, based on such
38 excess losses and such market shares for the immediately preceding cal-
39 endar year. Issuers of medicare supplement policies shall remit the
40 amount so assessed to the association within the time frames established
41 by the board for payment of assessment otherwise authorized herein. The
42 association shall pay to any issuer of medicare supplement policies enti-
43 tled thereto such amount as is necessary to result in the equalization

1 among all issuers of medicare supplement policies in Kansas of excess
2 losses in a proportion equivalent to the percentage market share in Kansas
3 of each issuer of medicare supplement policies covering persons eligible
4 for medicare by reason of age. The amount of such assessments received
5 by an insurer shall not be accounted for as premium income nor shall
6 such amounts be subject to premium tax. The amount of such assessments
7 shall not be available for use in premium tax credits provided for under
8 subsection (c) of K.S.A. 40-2122, and amendments thereto. The associ-
9 ation shall have the ability to enforce assessments through its board.

10 Sec. 16. K.S.A. 40-2209 is hereby amended to read as follows: 40-
11 2209. (a) (1) Group sickness and accident insurance is declared to be that
12 form of sickness and accident insurance covering groups of persons, with
13 or without one or more members of their families or one or more de-
14 pendents. Except at the option of the employee or member and except
15 employees or members enrolling in a group policy after the close of an
16 open enrollment opportunity, no individual employee or member of an
17 insured group and no individual dependent or family member may be
18 excluded from eligibility or coverage under a policy providing hospital,
19 medical or surgical expense benefits both with respect to policies issued
20 or renewed within this state and with respect to policies issued or renewed
21 outside this state covering persons residing in this state. For purposes of
22 this section, an open enrollment opportunity shall be deemed to be a
23 period no less favorable than a period beginning on the employee's or
24 member's date of initial eligibility and ending 31 days thereafter.

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

32 (A) The individual:

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

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

1 (iii) has lost coverage under another group policy providing hospital,
2 medical or surgical expense benefits or under section 607(1) of the em-
3 ployee retirement income security act of 1974 (ERISA) as a result of the
4 termination of employment, reduction in the number of hours of em-
5 ployment, termination of employer contributions toward such coverage,
6 the termination of the other policy's coverage, death of a spouse or di-
7 vorce or legal separation or was under a COBRA continuation provision
8 and the coverage under such provision was exhausted; and

9 (iv) requests enrollment within 30 days after the termination of cov-
10 erage under the other policy; or

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

13 (3) (A) If an accident and sickness insurer issues a group policy pro-
14 viding hospital, medical or surgical expenses and makes coverage available
15 to a dependent of an eligible employee or member and such dependent
16 becomes a dependent of the employee or member through marriage,
17 birth, adoption or placement for adoption, then such group policy shall
18 provide for a dependent special enrollment period as described in sub-
19 section (3) (B) of this section during which the dependent may be en-
20 rolled under the policy and in the case of the birth or adoption of a child,
21 the spouse of an eligible employee or member may be enrolled if oth-
22 erwise eligible for coverage.

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

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

35 (4) (A) No group policy providing hospital, medical or surgical ex-
36 pense benefits issued or renewed within this state or issued or renewed
37 outside this state covering residents within this state shall limit or exclude
38 benefits for specific conditions existing at or prior to the effective date of
39 coverage thereunder. Such policy may impose a preexisting conditions
40 exclusion, not to exceed 90 days following the date of enrollment for
41 benefits for conditions whether mental or physical, regardless of the cause
42 of the condition for which medical advice, diagnosis, care or treatment
43 was recommended or received in the 90 days prior to the effective date

1 of enrollment. Any preexisting conditions exclusion shall run concurrently
2 with any waiting period.

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

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

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

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

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

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

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

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

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

41 (8) Such policy shall waive such a preexisting conditions exclusion to
42 the extent the employee or member or individual dependent or family
43 member was covered by (A) a group or individual sickness and accident

1 policy, (B) coverage under section 607(1) of the employees retirement
2 income security act of 1974 (ERISA), (C) a group specified in K.S.A. 40-
3 2222 and amendments thereto, (D) part A or part B of title XVIII of the
4 social security act, (E) title XIX of the social security act, other than
5 coverage consisting solely of benefits under section 1928, (F) a state chil-
6 dren's health insurance program established pursuant to title XXI of the
7 social security act, (G) chapter 55 of title 10 United States code, (H) a
8 medical care program of the indian health service or of a tribal organi-
9 zation, (I) the Kansas uninsurable health plan act pursuant to K.S.A. 40-
10 2217 *et seq.* and amendments thereto or a similar health benefits risk pool
11 of another state, (J) a health plan offered under chapter 89 of title 5,
12 United States code, (K) a health benefit plan under section 5(e) of the
13 peace corps act (22 U.S.C. 2504(e), ~~or~~ (L) a group subject to K.S.A. 12-
14 2616 *et seq.* and amendments thereto which provided hospital, medical
15 and surgical expense benefits within 63 days prior to the effective date of
16 coverage with no gap in coverage *or* (M) *a group subject to section 1 et*
17 *seq. and amendments thereto which provided hospital, medical and sur-*
18 *gical expense benefits within 63 days prior to the effective date of coverage*
19 *with no gap in coverage.* A group policy shall credit the periods of prior
20 coverage specified in subsection (a)(7) without regard to the specific ben-
21 efits covered during the period of prior coverage. Any period that the
22 employee or member is in a waiting period for any coverage under a
23 group health plan or is in an affiliation period shall not be taken into
24 account in determining the continuous period under this subsection.

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

37 (2) The certification described in this subsection is a written certifi-
38 cation of (A) the period of coverage under a policy specified in subsection
39 (a) and any coverage under such COBRA continuation provision, and (B)
40 any waiting period imposed with respect to the eligible employee, mem-
41 ber or dependent for any coverage under such policy.

42 (c) Any group policy may impose participation requirements, define
43 full-time employees or members and otherwise be designed for the group

1 as a whole through negotiations between the group sponsor and the in-
2 surer to the extent such design is not contrary to or inconsistent with this
3 act.

4 (d) (1) An accident and sickness insurer offering a group policy pro-
5 viding hospital, medical or surgical expense benefits must renew or conti-
6 nue in force such coverage at the option of the policyholder or certifi-
7 cateholder except as provided in paragraph (2) below.

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

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

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

19 (C) if the policyholder or certificateholder has failed to comply with
20 a material plan provision relating to employer contribution or group par-
21 ticipation rules;

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

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

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

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

41 (A) The accident and sickness insurer notifies all policyholders and
42 certificateholders and all eligible employees or members of such discon-
43 tinuation at least 90 days prior to the date of the discontinuation of such

1 coverage;

2 (B) the accident and sickness insurer offers to each policyholder who
3 is provided such group policy providing hospital, medical or surgical ex-
4 pense benefits which is being discontinued the option to purchase any
5 other group policy providing hospital, medical or surgical expense bene-
6 fits currently being offered by such accident and sickness insurer; and

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

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

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

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

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

31 (e) An accident and sickness insurer offering a group policy providing
32 hospital, medical or surgical expense benefits may not establish rules for
33 eligibility (including continued eligibility) of any employee, member or
34 dependent to enroll under the terms of the group policy based on any of
35 the following factors in relation to the eligible employee, member or
36 dependent: (A) Health status, (B) medical condition, including both phys-
37 ical and mental illness, (C) claims experience, (D) receipt of health care,
38 (E) medical history, (F) genetic information, (G) evidence of insurability,
39 including conditions arising out of acts of domestic violence, or (H) dis-
40 ability. This subsection shall not be construed to require a policy providing
41 hospital, medical or surgical expense benefits to provide particular ben-
42 efits other than those provided under the terms of such group policy or
43 to prevent a group policy providing hospital, medical or surgical expense

1 benefits from establishing limitations or restrictions on the amount, level,
2 extent or nature of the benefits or coverage for similarly situated individ-
3 uals enrolled under the group policy.

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

6 (1) Under a policy issued to an employer or trustees of a fund estab-
7 lished by an employer, who is the policyholder, insuring at least two em-
8 ployees of such employer, for the benefit of persons other than the em-
9 ployer. The term "employees" shall include the officers, managers,
10 employees and retired employees of the employer, the partners, if the
11 employer is a partnership, the proprietor, if the employer is an individual
12 proprietorship, the officers, managers and employees and retired em-
13 ployees of subsidiary or affiliated corporations of a corporation employer,
14 and the individual proprietors, partners, employees and retired employ-
15 ees of individuals and firms, the business of which and of the insured
16 employer is under common control through stock ownership contract, or
17 otherwise. The policy may provide that the term "employees" may include
18 the trustees or their employees, or both, if their duties are principally
19 connected with such trusteeship. A policy issued to insure the employees
20 of a public body may provide that the term "employees" shall include
21 elected or appointed officials.

22 (2) Under a policy issued to a labor union which shall have a consti-
23 tution and bylaws insuring at least 25 members of such union.

24 (3) Under a policy issued to the trustees of a fund established by two
25 or more employers or business associations or by one or more labor un-
26 ions or by one or more employers and one or more labor unions, which
27 trustees shall be the policyholder, to insure employees of the employers
28 or members of the union or members of the association for the benefit
29 of persons other than the employers or the unions or the associations.
30 The term "employees" shall include the officers, managers, employees
31 and retired employees of the employer and the individual proprietor or
32 partners if the employer is an individual proprietor or partnership. The
33 policy may provide that the term "employees" shall include the trustees
34 or their employees, or both, if their duties are principally connected with
35 such trusteeship.

36 (4) A policy issued to a creditor, who shall be deemed the policyhol-
37 der, to insure debtors of the creditor, subject to the following require-
38 ments: (a) The debtors eligible for insurance under the policy shall be all
39 of the debtors of the creditor whose indebtedness is repayable in install-
40 ments, or all of any class or classes determined by conditions pertaining
41 to the indebtedness or to the purchase giving rise to the indebtedness.
42 (b) The premium for the policy shall be paid by the policyholder, either
43 from the creditor's funds or from charges collected from the insured

1 debtors, or from both.

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

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

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

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

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

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

42 (h) No group disability income policy which integrates benefits with
43 social security benefits, shall provide that the amount of any disability

1 benefit actually being paid to the disabled person shall be reduced by
2 changes in the level of social security benefits resulting either from
3 changes in the social security law or due to cost of living adjustments
4 which become effective after the first day for which disability benefits
5 become payable.

6 (i) A group policy of insurance delivered or issued for delivery or
7 renewed which provides hospital, surgical or major medical expense in-
8 surance, or any combination of these coverages, on an expense incurred
9 basis, shall provide that an employee or member or such employee's or
10 member's covered dependents whose insurance under the group policy
11 has been terminated for any reason, including discontinuance of the
12 group policy in its entirety or with respect to an insured class, and who
13 has been continuously insured under the group policy or under any group
14 policy providing similar benefits which it replaces for at least three
15 months immediately prior to termination, shall be entitled to have such
16 coverage nonetheless continued under the group policy for a period of
17 six months and have issued to the employee or member or such em-
18 ployee's or member's covered dependents by the insurer, at the end of
19 such six-month period of continuation, a policy of health insurance which
20 conforms to the applicable requirements specified in this subsection. This
21 requirement shall not apply to a group policy which provides benefits for
22 specific diseases or for accidental injuries only or a group policy issued to
23 an employer subject to the continuation and conversion obligations set
24 forth at title I, subtitle B, part 6 of the employee retirement income
25 security act of 1974 or at title XXII of the public health service act, as
26 each act was in effect on January 1, 1987 to the extent federal law provides
27 the employee or member or such employee's or member's covered de-
28 pendants with equal or greater continuation or conversion rights; or an
29 employee or member or such employee's or member's covered depend-
30 ents shall not be entitled to have such coverage continued or a converted
31 policy issued to the employee or member or such employee's or member's
32 covered dependents if termination of the insurance under the group pol-
33 icy occurred because:

34 (1) The employee or member or such employee's or member's cov-
35 ered dependents failed to pay any required contribution after receiving
36 reasonable notice of such required contribution from the insurer in ac-
37 cordance with rules and regulations adopted by the commissioner of in-
38 surance; (2) any discontinued group coverage was replaced by similar
39 group coverage within 31 days; (3) the employee or member is or could
40 be covered by medicare (title XVIII of the United States social security
41 act as added by the social security amendments of 1965 or as later
42 amended or superseded); or (4) the employee or member is or could be
43 covered to the same extent by any other insured or lawful self-insured

1 arrangement which provides expense incurred hospital, surgical or med-
2 ical coverage and benefits for individuals in a group under which the
3 person was not covered prior to such termination. In the event the group
4 policy is terminated and not replaced the insurer may issue an individual
5 policy or certificate in lieu of a conversion policy or the continuation of
6 group coverage required herein if the individual policy or certificate pro-
7 vides substantially similar coverage for the same or less premium as the
8 group policy. In any event, the employee or member shall have the option
9 to be issued a conversion policy which meets the requirements set forth
10 in this subsection in lieu of the right to continue group coverage.

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

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

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

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

36 (4) The effective date of the converted policy shall be the day follow-
37 ing the termination of insurance under the group policy.

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

42 (6) The insurer shall not be required to issue a converted policy cov-
43 ering any person if such person is or could be covered by medicare (title

1 XVIII of the United States social security act as added by the social se-
2 curity amendments of 1965 or as later amended or superseded). Fur-
3 thermore, the insurer shall not be required to issue a converted policy
4 covering any person if:

5 (A) (i) Such person is covered for similar benefits by another hos-
6 pital, surgical, medical or major medical expense insurance policy or hos-
7 pital or medical service subscriber contract or medical practice or other
8 prepayment plan or by any other plan or program, or

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

12 (iii) similar benefits are provided for or available to such person, pur-
13 suant to or in accordance with the requirements of any state or federal
14 law, and

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

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

27 (A) Such person is covered for similar benefits by another hospital,
28 surgical, medical or major medical expense insurance policy or hospital
29 or medical service subscriber contract or medical practice or other pre-
30 payment plan or by any other plan or program;

31 (B) such person is covered for similar benefits under any arrange-
32 ment of coverage for individuals in a group, whether on an insured or
33 uninsured basis; or

34 (C) similar benefits are provided for or available to such person, pur-
35 suant to or in accordance with the requirements of any state or federal
36 law.

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

40 (A) Either the benefits provided under the sources referred to in
41 clauses (A) (i) and (A) (ii) of paragraph 6 for such person or benefits
42 provided or available under the sources referred to in clause (A) (iii) of
43 paragraph 6 for such person, together with the benefits provided by the

1 converted policy, would result in over-insurance according to the insurer's
2 standards on file with the commissioner of insurance, or the converted
3 policyholder fails to provide the requested information;

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

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

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

10 (10) If the converted policy provides that any hospital, surgical or
11 medical benefits payable may be reduced by the amount of any such
12 benefits payable under the group policy after the termination of the in-
13 dividual's insurance or the converted policy includes provisions so that
14 during the first policy year the benefits payable under the converted pol-
15 icy, together with the benefits payable under the group policy, shall not
16 exceed those that would have been payable had the individual's insurance
17 under the group policy remained in force and effect, the converted policy
18 shall provide credit for deductibles, copayments and other conditions sat-
19 isfied under the group policy.

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

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

27 (i) The smaller of the following amounts:
28 The maximum benefit provided under the group policy or a maximum
29 payment of \$250,000 per covered person for all covered medical expenses
30 incurred during the covered person's lifetime.

31 (ii) The smaller of the following amounts:
32 The maximum benefit provided under the group policy or a maximum
33 payment of \$250,000 for each unrelated injury or sickness.

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

40 (C) A deductible for each benefit period which, at the option of the
41 insurer, shall be (i) the sum of the benefits deductible and \$100, or (ii)
42 the corresponding deductible in the group policy. The term "benefits
43 deductible," as used herein, means the value of any benefits provided on

1 an expense incurred basis which are provided with respect to covered
2 medical expenses by any other hospital, surgical, or medical insurance
3 policy or hospital or medical service subscriber contract or medical prac-
4 tice or other prepayment plan, or any other plan or program whether on
5 an insured or uninsured basis, or in accordance with the requirements of
6 any state or federal law and, if pursuant to the conditions of paragraph
7 (13), the converted policy provides both basic hospital or surgical cover-
8 age and major medical coverage, the value of such basic benefits.

9 If the maximum benefit is determined by clause (a)(ii) of this para-
10 graph, the insurer may require that the deductible be satisfied during a
11 period of not less than three months if the deductible is \$100 or less, and
12 not less than six months if the deductible exceeds \$100.

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

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

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

30 The insurer may also, in lieu of the plans of benefits set forth in par-
31 agraph (11), provide a policy of comprehensive medical expense benefits
32 without first dollar coverage. The policy shall conform to the require-
33 ments of paragraph (11). An insurer electing to provide such a policy shall
34 make available a low deductible option, not to exceed \$100, a high de-
35 ductible option between \$500 and \$1,000, and a third deductible option
36 midway between the high and low deductible options.

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

39 (14) In the event coverage would be continued under the group pol-
40 icy on an employee following the employee’s retirement prior to the time
41 the employee is or could be covered by medicare, the employee may
42 elect, in lieu of such continuation of group insurance, to have the same
43 conversion rights as would apply had such person’s insurance terminated

- 1 at retirement by reason of termination of employment or membership.
- 2 (15) The converted policy may provide for reduction of coverage on
3 any person upon such person's eligibility for coverage under medicare
4 (title XVIII of the United States social security act as added by the social
5 security amendments of 1965 or as later amended or superseded) or un-
6 der any other state or federal law providing for benefits similar to those
7 provided by the converted policy.
- 8 (16) Subject to the conditions set forth above, the continuation and
9 conversion privileges shall also be available:
- 10 (A) To the surviving spouse, if any, at the death of the employee or
11 member, with respect to the spouse and such children whose coverage
12 under the group policy terminates by reason of such death, otherwise to
13 each surviving child whose coverage under the group policy terminates
14 by reason of such death, or, if the group policy provides for continuation
15 of dependents' coverage following the employee's or member's death, at
16 the end of such continuation;
- 17 (B) to the spouse of the employee or member upon termination of
18 coverage of the spouse, while the employee or member remains insured
19 under the group policy, by reason of ceasing to be a qualified family
20 member under the group policy, with respect to the spouse and such
21 children whose coverage under the group policy terminates at the same
22 time; or
- 23 (C) to a child solely with respect to such child upon termination of
24 such coverage by reason of ceasing to be a qualified family member under
25 the group policy, if a conversion privilege is not otherwise provided above
26 with respect to such termination.
- 27 (17) The insurer may elect to provide group insurance coverage
28 which complies with this act in lieu of the issuance of a converted indi-
29 vidual policy.
- 30 (18) A notification of the conversion privilege shall be included in
31 each certificate of coverage.
- 32 (19) A converted policy which is delivered outside this state must be
33 on a form which could be delivered in such other jurisdiction as a con-
34 verted policy had the group policy been issued in that jurisdiction.
- 35 (20) The insurer shall give the employee or member and such em-
36 ployee's or member's covered dependents: (A) Reasonable notice of the
37 right to convert at least once during the six-month continuation period;
38 or (B) for persons covered under 29 U.S.C. 1161 et seq., notice of the
39 right to a conversion policy required by this subsection (d) shall be given
40 at least 30 days prior to the end of the continuation period provided by
41 29 U.S.C. 1161 et seq. or from the date the employer ceases to provide
42 any similar group health plan to any employee. Such notices shall be
43 provided in accordance with rules and regulations adopted by the com-

1 commissioner of insurance.

2 (k) (1) No policy issued by an insurer to which this section applies
3 shall contain a provision which excludes, limits or otherwise restricts cov-
4 erage because medicaid benefits as permitted by title XIX of the social
5 security act of 1965 are or may be available for the same accident or
6 illness.

7 (2) Violation of this subsection shall be subject to the penalties pre-
8 scribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

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

11 Sec. 17. K.S.A. 40-2209f is hereby amended to read as follows: 40-
12 2209f. Health benefit plans covering small employers that are issued or
13 renewed within this state or outside this state covering persons residing
14 in this state shall be subject to the following provisions, as applicable:

15 (a) Such policy may impose a preexisting conditions exclusion, not to
16 exceed 90 days following the date of enrollment, for conditions whether
17 physical or mental, regardless of the cause of the condition for which
18 medical advice, diagnosis, care or treatment was recommended or re-
19 ceived in the six months prior to the effective date of enrollment. Any
20 preexisting conditions exclusion shall run concurrently with any waiting
21 period.

22 (b) Such policy shall waive such a preexisting conditions exclusion to
23 the extent the employee or member or individual dependent or family
24 member was covered by (1) a group or individual sickness and accident
25 policy, (2) coverage under section 607(1) of the employees retirement
26 income security act of 1974 (ERISA), (3) a group specified in K.S.A. 40-
27 2222 and amendments thereto (4) part A or part B of title XVIII of the
28 social security act, (5) title XIX of the social security act, other than cov-
29 erage consisting solely of benefits under section 1928, (6) chapter 55 of
30 title 10 United States code, (7) a state children's health insurance program
31 established pursuant to title XXI of the social security act, (8) medical
32 care program of the indian health service or of a tribal organization, (9)
33 the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 *et seq.*
34 and amendments thereto or similar health benefits risk pool of another
35 state, (10) a health plan offered under chapter 89 of title 5, United States
36 code, (11) a health benefit plan under section 5(e) of the peace corps act
37 (22 U.S.C. 2504 (e) ~~or~~, (12) a group subject to K.S.A. 12-2616 *et seq.* and
38 amendments thereto which provided hospital, medical and surgical ex-
39 pense benefits within 63 days prior to the effective date of coverage under
40 a health benefit plan with no gap in coverage *or* (13) *a group subject to*
41 *section 1 et seq. and amendments thereto which provided hospital, med-*
42 *ical and surgical expense benefits within 63 days prior to the effective date*
43 *of coverage under a health benefit plan with no gap in coverage. A group*

1 policy shall credit the periods of prior coverage specified in this subsection
2 without regard to the specific benefits covered during the period of prior
3 coverage. Any period that the employee or member is in a waiting period
4 for any coverage under a group health plan or is in an affiliation period
5 shall be taken into account in determining the continuous period under
6 this subsection.

7 (c) A carrier may exclude a late enrollee except during an open en-
8 rollment period.

9 (d) Except as expressly provided by this act, every carrier doing busi-
10 ness in the small employer market retains the authority to underwrite and
11 rate individual accident and sickness insurance policies, and to rate small
12 employer groups using generally accepted actuarial practices.

13 (e) No health benefit plan issued by a carrier may limit or exclude,
14 by use of a rider or amendment applicable to a specific individual, cov-
15 erage by type of illness, treatment, medical condition or accident, except
16 for preexisting conditions as permitted under subsection (a).

17 (f) In the absence of the small employer's decision to the contrary,
18 all health benefit plans shall make coverage available to all the eligible
19 employees of a small employer without a waiting period. The decision of
20 whether to impose a waiting period for eligible employees of a small
21 employer shall be made by the small employer, who may only choose
22 from the waiting periods offered by the carrier. No waiting period shall
23 be greater than 90 days and shall permit coverage to become effective no
24 later than the first day of the month immediately following completion
25 of the waiting period.

26 (g) (1) Except as provided in subsection (f), requirements used by a
27 small employer carrier in determining whether to provide coverage to a
28 small employer, including requirements for minimum participation of el-
29 igible employees and minimum employer contributions, shall be applied
30 uniformly among all small employers with the same number of eligible
31 employees applying for coverage or receiving coverage from the small
32 employer carrier.

33 (2) A small employer carrier may vary application of minimum par-
34 ticipation requirements and minimum employer contribution require-
35 ments only by the size of the small employer group.

36 (3) (A) Except as provided in provision (B), in applying minimum
37 participation requirements with respect to a small employer, a small em-
38 ployer carrier shall not consider employees or dependents who have qual-
39 ifying existing coverage in a health benefit plan sponsored by another
40 employer in determining whether the applicable percentage of partici-
41 pation is met.

42 (B) With respect to a small employer, a small employer carrier may
43 consider employees or dependents who have coverage under another

1 health benefit plan sponsored by such small employer in applying mini-
2 mum participation requirements.

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

9 (i) For the purposes of this section, the term “date of enrollment”
10 means the date the individual is enrolled under the group policy or, if
11 earlier, the first day of the waiting period for such enrollment.

12 (j) For the purposes of this section, the term “waiting period” means
13 with respect to a group policy the period which must pass before the
14 individual is eligible to be covered for benefits under the terms of the
15 policy.

16 Sec. 18. K.S.A. 40-2259 is hereby amended to read as follows: 40-
17 2259. (a) As used in this section, “genetic screening or testing” means a
18 laboratory test of a person’s genes or chromosomes for abnormalities,
19 defects or deficiencies, including carrier status, that are linked to physical
20 or mental disorders or impairments, or that indicate a susceptibility to
21 illness, disease or other disorders, whether physical or mental, which test
22 is a direct test for abnormalities, defects or deficiencies, and not an in-
23 direct manifestation of genetic disorders.

24 (b) An insurance company, health maintenance organization, non-
25 profit medical and hospital, dental, optometric or pharmacy corporations,
26 ~~or~~ a group subject to K.S.A. 12-2616 et seq., and amendments thereto,
27 *or a group subject to section 1 et seq., and amendments thereto*, shall not:

28 (1) Require or request directly or indirectly any individual or a mem-
29 ber of the individual’s family to obtain a genetic test;

30 (2) require or request directly or indirectly any individual to reveal
31 whether the individual or a member of the individual’s family has ob-
32 tained a genetic test or the results of the test, if obtained by the individual
33 or a member of the individual’s family;

34 (3) condition the provision of insurance coverage or health care ben-
35 efits on whether an individual or a member of the individual’s family has
36 obtained a genetic test or the results of the test, if obtained by the indi-
37 vidual or a member of the individual’s family; or

38 (4) consider in the determination of rates or any other aspect of in-
39 surance coverage or health care benefits provided to an individual
40 whether an individual or a member of the individual’s family has obtained
41 a genetic test or the results of the test, if obtained by the individual or a
42 member of the individual’s family.

43 (c) Subsection (b) does not apply to an insurer writing life insurance,

- 1 disability income insurance or long-term care insurance coverage.
- 2 (d) An insurer writing life insurance, disability income insurance or
3 long-term care insurance coverage that obtains information under para-
4 graphs (1) or (2) of subsection (b), shall not:
- 5 (1) Use the information contrary to paragraphs (3) or (4) of subsec-
6 tion (b) in writing a type of insurance coverage other than life for the
7 individual or a member of the individual's family; or
- 8 (2) provide for rates or any other aspect of coverage that is not rea-
9 sonably related to the risk involved.
- 10 Sec. 19. K.S.A. 40-3606 is hereby amended to read as follows: 40-
11 3606. This act shall apply to all insurance companies, fraternal benefit
12 societies, health maintenance organizations, reciprocal insurance ex-
13 changes, mutual nonprofit hospital and medical service corporations, cap-
14 tive insurance companies, group-funded pools except municipal group
15 funded pools governed by K.S.A. 12-2616 through 12-2629 and amend-
16 ments thereto *and adult care home group-funded pools governed by sec-*
17 *tions 1 through 14 and amendments thereto*, prepaid service plans oper-
18 ating under article 19a of chapter 40 of the Kansas Statutes Annotated,
19 regardless of whether such entities are authorized to do business in this
20 state, and such entities which are in the process of organization.
- 21 Sec. 20. K.S.A. 44-559a is hereby amended to read as follows: 44-
22 559a. (a) Each insurer issuing a policy to assure the payment of compen-
23 sation under the workers compensation act may offer, as a part of the
24 policy or as an optional endorsement to the policy, deductibles optional
25 to the policyholder for benefits, which may include allocated loss adjust-
26 ment expenses, payable under the workers compensation act.
- 27 (b) The insurer shall pay all or part of the deductible amount, which-
28 ever is applicable to a compensable claim, to the person or medical pro-
29 vider entitled to the benefits conferred by the workers compensation act
30 and seek reimbursement from the insured employer for the applicable
31 deductible amount. The payment or nonpayment of deductible amounts
32 by the insured employer to the insurer shall be treated under the policy
33 insuring the liability for workers compensation in the same manner as
34 payment or nonpayment of premiums. The insurer may require adequate
35 security to provide for reimbursement of the paid deductible from the
36 insured. An employer's failure to reimburse deductible amounts to the
37 insurer shall not cause the deductible amount to be paid from the workers
38 compensation fund under K.S.A. 44-532a and amendments thereto or
39 any other statute. The insurer shall have the right to offset unpaid de-
40 ductible amounts against unearned premium, if any, in the event of
41 cancellation.
- 42 (c) Such deductible shall provide premium credits as approved by the
43 commissioner of insurance, and losses paid by the employer under the

1 deductible shall not apply in calculating the employer's experience
2 modification.

3 (d) The commissioner of insurance shall not approve any policy form
4 that permits, directly or indirectly, any part of the deductible to be
5 charged to or be passed on to the worker.

6 (e) The deductible amounts paid by an employer shall be subject to
7 reimbursement as provided for under K.S.A. 44-567 and amendments
8 thereto when applicable. All compensation benefits paid by the insurer
9 including the deductible amounts shall be subject to assessments under
10 K.S.A. 44-566a and 74-713 and amendments thereto. The Kansas workers
11 compensation plan under K.S.A. 40-2109 and amendments thereto shall
12 not require deductibles under policies issued by the plan.

13 (f) Group-funded worker compensation pools as defined in K.S.A.
14 44-581, and amendments thereto, ~~and~~ municipal group-funded pools as
15 defined in K.S.A. 12-2616, and amendments thereto, *and adult care home*
16 *group-funded pools as defined in section 1, and amendments thereto*, may
17 offer deductibles as defined herein using deductible rules and premium
18 credits as promulgated by the national council on compensation insurance
19 and approved by the commissioner.

20 Sec. 21. K.S.A. 65-474 is hereby amended to read as follows: 65-474.
21 Each individual and group policy of accident and sickness insurance, each
22 contract issued by health maintenance organizations and all coverage
23 maintained by an entity authorized under K.S.A. 40-2222 and amend-
24 ments thereto ~~or~~, by a municipal group-funded pool authorized under
25 K.S.A. 12-2618 and amendments thereto *or by an adult care home group-*
26 *funded pool authorized under section 3 and amendments thereto* shall
27 provide benefits for services when performed by a critical access hospital
28 if such services would be covered under such policies or contracts if per-
29 formed by a general hospital.

30 Sec. 22. K.S.A. 40-2121, 40-2209, 40-2209f, 40-2259, 40-3606, 44-
31 559a and 65-474 are hereby repealed.

32 Sec. 23. This act shall take effect and be in force from and after its
33 publication in the statute book.