Session of 2005

HOUSE BILL No. 2294

By Committee on Appropriations

2-3

AN ACT enacting the adult care home group-funded pool act; authorizing adult care homes to pool liabilities; providing certificate of authority to operate pools and providing for the regulation thereof; amending K.S.A. 40-2121, 40-2209f, 40-2259, 40-3606, 44-559a and 65-474 and K.S.A. 2004 Supp. 40-2209 and repealing the existing sections.

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

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

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

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

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

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

(b) Designation of the initial board of trustees and administrator. When there is a change in the membership of the board of trustees or change of administrator, the pool shall notify the commissioner within 30 days after such change.

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

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

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

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

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

(h) A confirmation that specific and aggregate excess insurance provided by an insurance company is or will be in effect concurrent with the assumption of risk by the pool, as selected by the board of trustees of the pool, or adequate surplus funds as approved by the commissioner, in the pool. The pool shall notify the commissioner within 30 days of any change in the specific and aggregate excess insurance carried by the pool. For the purposes hereof, "surplus funds" shall mean retained earnings of the pool after reserves have been established for all known and incurred but not reported losses of the pool and after all other liabilities of the pool,

including unearned premium reserves, have been deducted from total assets. The term "adequate surplus funds" shall mean the amount necessary for the pool to fund its self-insured obligations.

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

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

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

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

(b) Whenever the commissioner shall deem it necessary the commissioner may make, or direct to be made, an examination of the affairs and the financial condition of any pool, except that once every five years the commissioner shall conduct an examination of the affairs and the financial condition of each pool. Each pool shall submit a certified independent audited financial statement no later than 90 days after the end of the fiscal year. The financial statement shall include outstanding reserves for claims and for claims incurred but not reported. Each pool shall file reports as to income, expenses and loss data at such times and in such manner as the commissioner shall require. Any pool which does not use rates developed by an approved rating organization shall file with the commissioner an actuarial certification that such rates are actuarially sound. Whenever it appears to the commissioner from such examination or other satisfactory evidence that the ability to pay current and future claims of any such pool is impaired, or that it is doing business in violation of any of the laws of this state, or that its affairs are in an unsound condition so as to endanger its ability to pay or cause to be paid claims in the

amount, manner and time due, the commissioner shall, before filing such report or making the same public, grant such pool upon reasonable notice a hearing, and, if on such hearing the report be confirmed, the commissioner may require any of the actions allowed under K.S.A. 40-222b and amendments thereto or suspend the certificate of authority for such pool until its ability to pay current and future claims shall have been fully restored and the laws of the state fully complied with. The commissioner may, if there is an unreasonable delay in restoring the ability to pay claims of such pool and in complying with the law or if rehabilitation or corrective action taken under K.S.A. 40-222b and amendments thereto is unsuccessful, revoke the certificate of authority of such pool to do business in this state. Upon revoking any such certificate the commissioner shall communicate the fact to the attorney general, whose duty it shall be to commence and prosecute an action in the proper court to dissolve such pool or to enjoin the same from doing or transacting business in this state. The commissioner of insurance may call a hearing under K.S.A. 40-222b, and amendments thereto, and the provisions thereof shall apply to group-funded pools.

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

New Sec. 6. (a) With respect to the categories of coverage described in subparagraphs (d)(1) through (4) of section 3, and amendments thereto, premium contributions to the pool shall be based upon appropriate manual classification and rates, plus or minus applicable experience credits or debits, and minus any advance discount approved by the trustees, not to exceed 25% of manual premium. The pool shall use rules, classifications and rates as promulgated by an approved rating organization for workers compensation. Premium contributions to the pool for all other lines of insurance shall be based on rates filed by a licensed rating organization or on rates of certain companies filing rates with the commissioner and approved by the commissioner for the pool. In lieu of the foregoing, the board of trustees may determine such classification, rates and discounts as approved by the commissioner.

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

(b) An amount equal to at least 70% of the annual premium shall be maintained in a designated depository for the purpose of paying claims in a claims fund account. The remaining annual premium shall be placed into a designated depository for the payment of taxes, fees and administrative and other operational costs in an administrative fund account. The

payment of excess insurance may be paid from the annual premium prior to the division of premium into claims and administrative fund accounts.

(c) Any moneys for a fund year in excess of the amount necessary to fulfill all obligations of the pool for that fund year, including any obligation to retain adequate surplus funds, as defined by subsection (h) of section 3, and amendments thereto, in lieu of specific and aggregate excess insurance, may be declared to be refundable by the trustees not less than 12 months after the end of the fund year. Any such refund shall be paid only to those members who remained participants in the pool for an entire year. Payment of previously earned refunds shall not be contingent on continued membership in the pool.

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

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

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

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

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

New Sec. 9. In addition to any fees required to be paid under this act, and as a condition precedent to the continuation of the certificate of authority provided in this act, all group-funded pools shall pay no later

than 90 days after the end of each fiscal year a tax upon the annual Kansas gross premium collected by the pool at the rate of 1% per annum applied to the collective premium relating to all Kansas members of the pool for the preceding fiscal year. In the computation of the tax, all pools shall be entitled to deduct any annual Kansas gross premiums returned on account of cancellation or dividends returned to members of such pools or expenditures used for the purchase of specific and aggregate excess insurance, as provided in subsection (h) of section 3 and amendments thereto.

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

(b) Each proposed and authorized pool and each person representing such proposed or authorized pool shall be subject to the provisions of the statutes contained in article 24 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

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

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

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

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

(c) Individual members may elect to terminate their participation in a pool or be subject to cancellation by the pool pursuant to the bylaws of the pool. On termination or cancellation of a workers' compensation member, the pool shall notify the division of workers' compensation within 10 days and shall maintain coverage of each canceled or terminating member for 30 days after notice to such division or until such division

gives notice that the canceled or terminating member has procured workers' compensation and employers' liability insurance, whichever occurs first.

New Sec. 12. To ensure the financial stability of the operations of each group-funded pool, the board of trustees of each pool is responsible for all operations of the pool. The board of trustees shall consist of not less than three persons selected according to the bylaws of the pool for stated terms of office to direct the administration of a pool, and whose duties include approving applications by new members of the pool. The majority of the trustees must be a member of the governing body or an officer or employee of members of the pool, but a trustee may not be an owner, officer or employee of any service agent or representative. All trustees shall be residents of this state. The board of trustees of each fund shall take all necessary precautions to safeguard the assets of the fund, including all of the following:

(a) Designate an administrator to administer the financial affairs of the pool who shall furnish a fidelity bond to the pool in an amount determined by the trustees to protect the pool against the misappropriation or misuse of any moneys or securities. The administrator shall file evidence of the bond with the commissioner. The bond shall be one of the conditions required for approval of the establishment and continued operation of a pool. Any administrator so designated shall be a resident of Kansas if an individual or shall be authorized to do business in Kansas if a corporation.

(b) Retain control of all moneys collected or disbursed from the pool and segregate all moneys into a claims fund account and an administrative fund account. All administrative costs and other disbursements shall be made from the administrative fund account. The trustees may establish a revolving fund for use by the authorized service agent which is replenished from time to time from the claims fund account. The service agent and its employees shall be covered by a fidelity bond, with the pool as obligee, in an amount sufficient to protect all moneys placed in the revolving fund.

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

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

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

(f) The board of trustees may delegate authority for specific functions

to the administrator of the pool. The functions which the board may delegate include such matters as contracting with a service agent, determining the premium chargeable to and refunds payable to members, investing surplus moneys and approving applications for membership. The board of trustees shall specifically define all authority it delegates in the written minutes of the trustees' meetings. Any delegation of authority shall not be effective without a formal resolution passed by the trustees.

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

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

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

of the association in meeting the incurred or estimated claims expenses of the plan and the operating and administrative expenses of the plan.

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

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

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

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

(d) In addition to the assessments otherwise authorized herein, the board shall assess all issuers of medicare supplement policies covering persons within this state to the extent necessary to assure that the excess losses, if any, are distributed among such issuers of medicare supplement policies in a ratio equal to the percentage market share in Kansas of each such issuer for medicare supplement policies covering persons eligible for medicare by reason of age. The association shall also assess to such

issuers of medicare supplement policies the costs the association incurs in operating the reinsurance program, making assessments, and collecting and distributing moneys, which shall be assessed pro rata to such issuers based on the market share of such issuers of medicare supplement policies covering persons eligible for medicare by reason of age. Such assessment shall occur not later than July 1 of each year, based on such excess losses and such market shares for the immediately preceding calendar year. Issuers of medicare supplement policies shall remit the amount so assessed to the association within the time frames established by the board for payment of assessment otherwise authorized herein. The association shall pay to any issuer of medicare supplement policies entitled thereto such amount as is necessary to result in the equalization among all issuers of medicare supplement policies in Kansas of excess losses in a proportion equivalent to the percentage market share in Kansas of each issuer of medicare supplement policies covering persons eligible for medicare by reason of age. The amount of such assessments received by an insurer shall not be accounted for as premium income nor shall such amounts be subject to premium tax. The amount of such assessments shall not be available for use in premium tax credits provided for under subsection (c) of K.S.A. 40-2122, and amendments thereto. The association shall have the ability to enforce assessments through its board.

Sec. 16. K.S.A. 2004 Supp. 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 *or (M) a group subject to section 1 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 sur-

gical 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); (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 indi-

vidual 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.

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

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

(b) 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 (1) a group or individual sickness and accident policy, (2) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA), (3) a group specified in K.S.A. 40-2222 and amendments thereto (4) part A or part B of title XVIII of the social security act, (5) title XIX of the social security act, other than cov-

erage consisting solely of benefits under section 1928, (6) chapter 55 of title 10 United States code, (7) a state children's health insurance program established pursuant to title XXI of the social security act, (8) medical care program of the indian health service or of a tribal organization, (9) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 *et seq.* and amendments thereto or similar health benefits risk pool of another state, (10) a health plan offered under chapter 89 of title 5, United States code, (11) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504 (e) ~~or~~, (12) 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 under a health benefit plan with no gap in coverage *or (13) a group subject to section 1 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 63 days prior to the effective date of coverage under a health benefit plan with no gap in coverage*. A group policy shall credit the periods of prior coverage specified in this subsection 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 be taken into account in determining the continuous period under this subsection.

(c) A carrier may exclude a late enrollee except during an open enrollment period.

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

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

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

(g) (1) Except as provided in subsection (f), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of el-

igible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(2) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(3) (A) Except as provided in provision (B), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in a health benefit plan sponsored by another employer in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(h) 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.

(i) 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.

(j) 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.

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

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

(1) Require or request directly or indirectly any individual or a mem-

ber of the individual's family to obtain a genetic test;

(2) require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family;

(3) condition the provision of insurance coverage or health care benefits on whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family; or

(4) consider in the determination of rates or any other aspect of insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family.

(c) Subsection (b) does not apply to an insurer writing life insurance, disability income insurance or long-term care insurance coverage.

(d) An insurer writing life insurance, disability income insurance or long-term care insurance coverage that obtains information under paragraphs (1) or (2) of subsection (b), shall not:

(1) Use the information contrary to paragraphs (3) or (4) of subsection (b) in writing a type of insurance coverage other than life for the individual or a member of the individual's family; or

(2) provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

Sec. 19. K.S.A. 40-3606 is hereby amended to read as follows: 40-3606. This act shall apply to all insurance companies, fraternal benefit societies, health maintenance organizations, reciprocal insurance exchanges, mutual nonprofit hospital and medical service corporations, captive insurance companies, group-funded pools except municipal group funded pools governed by K.S.A. 12-2616 through 12-2629 and amendments thereto *and adult care home group-funded pools governed by sections 1 through 14 and amendments thereto*, prepaid service plans operating under *the statutes contained in* article 19a of chapter 40 of the Kansas Statutes Annotated, *and amendments thereto,* regardless of whether such entities are authorized to do business in this state, and such entities which are in the process of organization.

Sec. 20. K.S.A. 44-559a is hereby amended to read as follows: 44-559a. (a) Each insurer issuing a policy to assure the payment of compensation under the workers compensation act may offer, as a part of the policy or as an optional endorsement to the policy, deductibles optional to the policyholder for benefits, which may include allocated loss adjustment expenses, payable under the workers compensation act.

(b) The insurer shall pay all or part of the deductible amount, which-

ever is applicable to a compensable claim, to the person or medical provider entitled to the benefits conferred by the workers compensation act and seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer shall be treated under the policy insuring the liability for workers compensation in the same manner as payment or nonpayment of premiums. The insurer may require adequate security to provide for reimbursement of the paid deductible from the insured. An employer's failure to reimburse deductible amounts to the insurer shall not cause the deductible amount to be paid from the workers compensation fund under K.S.A. 44-532a and amendments thereto or any other statute. The insurer shall have the right to offset unpaid deductible amounts against unearned premium, if any, in the event of cancellation.

(c) Such deductible shall provide premium credits as approved by the commissioner of insurance, and losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification.

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

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

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

Sec. 21. K.S.A. 65-474 is hereby amended to read as follows: 65-474. Each individual and group policy of accident and sickness insurance, each contract issued by health maintenance organizations and all coverage maintained by an entity authorized under K.S.A. 40-2222 and amendments thereto ~~or~~, by a municipal group-funded pool authorized under K.S.A. 12-2618 and amendments thereto *or by an adult care home group-funded pool authorized under section 3 and amendments thereto* shall provide benefits for services when performed by a critical access hospital

if such services would be covered under such policies or contracts if performed by a general hospital.

Sec. 22. K.S.A. 40-2121, 40-2209f, 40-2259, 40-3606, 44-559a and 65-474 and K.S.A. 2004 Supp. 40-2209 are hereby repealed.

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