Session of 2007

HOUSE BILL No. 2591

By Committee on Appropriations

3-21

AN ACT enacting the foundations of health reform act of 2007; amending K.S.A. 39-785 and 40-2215 and K.S.A. 2006 Supp. 39-709, 40-19c06, 40-2209, 40-3209, 75-6501 and 75-7408 and repealing the existing sections; also repealing K.S.A. 2006 Supp. 39-709d.

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

New Section 1. Sections 1 through 11 of this act shall be known and may be cited as the Kansas medicaid reform act of 2007.

New Sec. 2. The health policy oversight committee and the Kansas health policy authority shall work together to write state plan amendments and waivers to implement the Kansas medicaid reform act of 2007. The Kansas health policy authority shall request the federal centers for medicare and medicaid to appoint a special representative to work with the health policy authority to expedite, coordinate and implement the changes to the medicaid program in Kansas and to request additional transition funds.

New Sec. 3. (a) The Kansas health policy authority is authorized to seek waivers or other federal authorizations, or both, to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Kansas medicaid program.

(b) The Kansas health policy authority shall develop and submit for approval, applications for waivers of applicable federal laws and regulations as necessary to implement the provisions of the Kansas medicaid reform act of 2007. Copies of all waivers submitted to and approved by the United States centers for medicare and medicaid services under this section shall be provided to the joint committee on health policy oversight prior to submission and within 10 days of their approval. The Kansas health policy authority shall submit a plan containing a recommended timeline for implementation of any waivers and budgetary projections of the effect of the Kansas medicaid reform act of 2007. This implementation plan shall be submitted to the governor, the speaker of the house of representatives, the president of the senate and the joint committee on health policy oversight.

(1) After consultation with the proper legislative and executive

branch officials, the executive director of the Kansas health policy authority shall seek a waiver for the following purposes:

(A) A waiver or state plan amendment to request a centers for medicare and medicaid services representative for expedited implementation and evaluation of the state's:

(1) Long-term care system;

(2) state children's health insurance program; and

(3) general medicaid system;

(B) waste, fraud and abuse waivers, including waivers to look at waste, fraud and abuse that occur with medicaid and with long-term care;

(C) a block grant multi-year waiver if deemed feasible;

(D) a waiver to keep recovery payments from worker's compensation, liability, estate recovery and noncustodial parents;

(E) a waiver for tax credits and vouchers;

(F) a waiver for wellness, obesity and smoking programs; and

(G) a waiver for medicaid uninsured funding, including, but not limited to, community health clinics to be block granted to the community health centers, a free care pool, access grants, studies used for targeting the uninsured population and various subgroups of the uninsured population.

(c) By July 1, 2008, phase one of this act shall be implemented within a contiguous area of the state with rural and urban characteristics. The Kansas health policy authority shall contract for an independent evaluation and report findings of this phase of the act to the governor and the legislature. After an independent evaluation and report to the governor and legislature, if it is determined that the evaluation establishes improved access to health care, improved health care outcomes, and improved cost efficiencies, it is the intent of the legislature that components of the act be phased in statewide by the year 2013.

(d) Upon this evaluation and determination of improvement by the governor and legislature, the Kansas health policy authority shall negotiate a plan for statewide expansion of the act from the centers for medicare and medicaid services.

(e) The purpose of the Kansas medicaid reform act of 2007 is to:

(1) Provide medicaid consumers who are younger than 65 years of age multiple options in the selection of health care plans and health savings accounts that meet the needs of consumers and allows consumers to exercise greater control over the medical care that consumers receive;

(2) stabilize medicaid expenditures in the test areas compared to medicaid expenditures in the test areas for the three years preceding implementation of the act, while ensuring:

(A) Consumer education and choice;

(B) access to medically necessary services;

(C) coordination of preventative, acute, and long-term care services; and

(D) reductions in unnecessary service utilization;

(3) provide an opportunity to evaluate the progress of statewide implementation of the Kansas medicaid reform act of 2007 as a replacement for the current medicaid system;

(4) introduce competition and market forces as major factors that lower the cost of the act; and

(5) design insurance policies which are portable and renewable once a recipient leaves medicaid.

New Sec. 4. (a) The Kansas health policy authority shall have the following powers, duties and responsibilities with respect to the development of the program established in section 3 of this act:

(1) Provide a consumer education component which shall:

(A) Develop a choice counseling system to ensure that the choice counseling process and related material are designed to provide consumers an understanding of both public and private health insurance options provided by this act including incentives through face-to-face interaction, by telephone, by internet and in writing, and through other forms of relevant media;

(B) develop a system to ensure that there is a record of recipient acknowledgment that choice counseling has been provided; and

(C) develop a choice counseling system that promotes health literacy and includes an educational component that is intended to promote proper utilization of the health care system;

(2) provide a consumer choice component which shall:

(A) Develop a system to enable insurable medicaid consumers to access commercial health insurance policies;

(B) develop an actuarially sound cost per medicaid consumer within different age groups and other relevant categories including health status to provide medically necessary services which may be separated to cover comprehensive care, enhanced services and catastrophic care. This cost would be converted into a credit or instrument of value for the medicaid consumer to purchase qualified health insurance policies;

(C) determine, in conjunction with the Kansas insurance department, benefits and standards for commercial insurers accessed by medicaid consumers;

(D) allow consumers to purchase health care coverage through an employer-sponsored health insurance plan instead of through a qualified health insurance plan. This provision shall be known as the employee choice option. A recipient who chooses the medicaid employee choice option shall have an opportunity for a specified period of time, as authorized by the centers for medicare and medicaid services, to select and

enroll in a qualified health insurance plan;

(E) develop a process for medicaid consumers to select commercial health insurance options using the Kansas insurance exchange as well as premium assistance;

(F) develop a plan to implement a health opportunity account system as a benefit. Moneys deposited into a health opportunity account shall only be used by the recipient to defray health-care related costs including, but not limited to, copayments, noncovered benefits, wellness initiatives and future health insurance once a health opportunity account holder leaves medicaid.

(i) Contributions to the health opportunity account shall be made annually by the state and may be made by other persons and entities, such as charitable organizations, as permitted by federal law;

(ii) the account holder shall receive rewards for making healthy lifestyle choices; such as, but not limited to: Quitting smoking, losing excess weight, implementing a physical exercise routine and other wellness endeavors;

(iii) funds remaining in the account at the end of the enrollment period shall rollover into the next enrollment period. The health policy authority shall promulgate rules and regulations guiding health opportunity account transactions;

(3) provide a grievance-resolution process for medicaid consumers enrolled in a health plan. This process shall include a mechanism for an expedited review of a grievance if the life of a medicaid recipient is in imminent and emergent jeopardy;

(4) provide a grievance-resolution process for health care providers employed by or contracted with a health plan to settle disputes among the provider and the health plan or the provider and the Kansas health policy authority;

(5) institute by July 1, 2008, cost-sharing methods or benefit modifications, or both, within current federal medicaid limitations;

(6) develop mechanisms to transfer medicaid recipients to the health earned income tax credit by 2009;

(7) develop a system to ensure that the implementation of the provisions of this act do not negatively affect the ability of American Indian or Alaska native beneficiaries to access services at Indian health service facilities, tribally operated health facilities and urban Indian health programs;

(8) develop mechanisms through intergovernmental transfers which will allow tribally operated facilities that elect to provide services to beneficiaries other than American Indian or Alaska native beneficiaries to receive reimbursement for such services.

(b) Notwithstanding any other provision of this section, coverage, cost

sharing, and any other component of employer-sponsored health insurance shall be governed by applicable state and federal laws.

New Sec. 5. (a) The Kansas health policy authority shall conduct a needs analysis to design a database of clinical utilization information or electronic medical records for medicaid providers. This system shall be based and funded in the private sector by 2013. This system shall be web-based and allow providers to review on a real-time basis the utilization of medicaid services including, but not limited to, office visits, inpatient and outpatient hospitalizations, laboratory and pathology services, radiological and other imaging services, dental care, and patterns of dispensing prescription drugs in order to coordinate care and identify potential fraud and abuse. The Kansas health policy authority shall evaluate and report findings to the governor and the legislature by January 1, 2009.

(b) The Kansas health policy authority shall design and implement an electronic prescribing pilot program. This system shall be based and funded in the private sector by 2013. The pilot program may include, but is not limited to, providing hardware, software, and connectivity for a limited number of prescribers. The prescribers who participate may be given vouchers for hardware, software, and connectivity, or the Kansas health policy authority may use direct vendor contracts. The Kansas health policy authority shall:

(1) Within the messaging capabilities of the electronic prescribing system alert prescribers when patients are prescribed multiple drugs that may be duplicative, contraindicated, or have other potential problems related either to other medications or health status of the patient;

(2) track spending trends for prescription drugs and deviation from best-practice guidelines and notify prescribers who consistently fall outside those guidelines, comparing those prescribers who are using the electronic prescribing system to those who are not in order to determine whether the pilot program should be expanded; and

(3) in conjunction with disease management programs or other targeted interventions, alert prescribers to patients who fail to refill ongoing or maintenance medication prescriptions in a timely fashion.

(c) A report of this pilot program shall be submitted to the governor and the legislature no later than 18 months after the start of the program.

New Sec. 6. (a) The Kansas health policy authority in cooperation with the state department of health and environment, the joint committee on health policy oversight, a statewide organization of the elderly, representatives of the task force on long-term care services, the state long-term care ombudsman and representatives of the three statewide associations of nursing facility operators and representatives of the Kansas insurance exchange shall convert medicaid recipients of long-term care benefits to commercially based insurance that reimburses providers on

the basis of:

(1) Market based pricing mechanisms;

(2) reimbursement following the patient;

(3) rewarding quality of care indicators;

(4) whenever possible using counseling and health opportunity accounts for consumer driven choices; and

(5) giving recipients multiple choices of health plans.

(b) The Kansas health policy authority shall negotiate with the centers for medicare and medicaid services to include the authority to base provider reimbursement rates on the criteria specified in subsection (a) of this section.

New Sec. 7. The Kansas health policy authority shall develop and administer a plan for the implementation of alternatives for long-term care. The plan shall include, but not be limited to:

(a) The continued development and funding of community-based options throughout the state of Kansas;

(b) the establishment of a long-term care opportunity account for medicaid recipients receiving long-term care services, in home or out of home, with graduating benefits and a counseling program that focuses on increasing personal responsibility, efficiency in utilization and consumer satisfaction;

(1) Moneys deposited into a long-term care opportunity account shall only be used by the recipient to defray health-care related costs, including, but not limited to, copayments, noncovered benefits, activities of daily living and other services typically rendered to persons needing long-term care, services typically rendered by medicaid and wellness initiatives;

(2) contributions to the long-term care opportunity account shall be made annually by the state and may be made by other persons and entities, such as charitable organizations, as permitted by federal law;

(3) the account holder shall receive rewards for making healthy lifestyle choices; such as, but not limited to: Quitting smoking, losing excess weight, implementing a physical exercise routine or other wellness endeavors;

(4) funds remaining in the account at the end of the enrollment period shall rollover into the next enrollment period;

(5) if the recipient of the long-term care opportunity account dies, the moneys in such account shall revert to the state;

(c) the establishment of a program providing for state incentives to Kansas citizens for long-term care planning, including providing multiple choices of long-term care insurance plans and insurers with the goal of phasing out traditional medicaid expenses in five years; and

(d) stronger private and public partnerships at the community level in order to address unmet patient needs.

New Sec. 8. (a) The Kansas health policy authority shall continue to develop and administer a program that will encourage the timely and appropriate use of primary care services in lieu of emergency room utilization. The program shall include, but not be limited to, the implementation of:

(1) Educational strategies;

(2) technology-based monitoring; and

(3) co-payment structures as provided for in section 4 of this act with higher copays for nonessential emergency room use.

(b) The Kansas health policy authority may develop a pilot program utilizing state-licensed health care professionals to perform educational interventions with consumers who highly utilize emergency room services or to perform other services to reduce unnecessary emergency room visits.

(c) The Kansas health policy authority shall develop and implement a telephone information health line pilot program under which physicians or nurses are available by telephone twenty-four hours a day to answer medical questions and provide health information for the medicaid population. If the health policy authority determines that the pilot program reduces unnecessary emergency room visits and the pilot program demonstrates a net cost-savings, the health policy authority shall expand the program into a statewide initiative.

(d) The Kansas health policy authority shall evaluate and report findings to the governor, the legislature and the joint committee on health policy oversight by January 1, 2010.

(e) The Kansas health policy authority shall promulgate rules and regulations to implement the provisions of this section.

New Sec. 9. The Kansas health policy authority shall establish a method to deter abuse and reduce errors in medicaid billing, payment and eligibility through the use of market forces and technology and accountability measures for the authority, providers and consumers. The authority shall achieve a payment error rate measurement of no greater than 5% by fiscal year 2009. The Kansas health policy authority shall evaluate and report findings to the governor, the legislature and the joint committee on health policy oversight. The Kansas health policy authority in conjunction with the insurance commissioner shall advise the legislature on methods to decrease waste, fraud and abuse by January 1, 2008.

New Sec. 10. The Kansas health policy authority in consultation with health care providers shall study a discount program for hospital charges for qualified self-pay patients and report its recommendations to the legislature by January 1, 2008.

New Sec. 11. (a) All entities providing health insurance or health care coverage to individuals residing within the state shall provide such

information on coverage and benefits as may be required by any health care provider, health plan, health plan sponsor or their agent regarding the coverage provided by the entity to any patient or beneficiary of the medical service provider, health plan, or health plan sponsor.

(b) Any health care provider, health plan, health plan sponsor or their agent is authorized to transmit the simple human identifiers in ANSI X.12 270 inquiries including the name, gender, date of birth, and member number or policyholder identification number if required by the health plan of a patient to any and all entities licensed or registered to provide health insurance or health care coverage to individuals residing within the state to establish the coverage in force for a patient presenting or about to present a claim.

(c) Any health care provider, health plan, health plan sponsor or their agent or the Kansas insurance exchange is authorized to disclose to the department of revenue and other governmental entities whether a recipient has health insurance coverage or other data necessary for implementation of tax credits and other assistance programs.

(d) Any party named in subsection (a) of this section shall have a cause of action for injunctive relief and costs including, but not limited to, attorney fees for the enforcement of this section against any noncompliant health plan.

New Sec. 12. Sections 12 through 16, and amendments thereto, shall be known and may be cited as the "long-term care partnership program act."

New Sec. 13. As used in sections 13 through 17, and amendments thereto:

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

(b) "Long-term care insurance policy" means a policy as defined in K.S.A. 40-2227, and amendments thereto.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in section 1917(b) of the social security act, 42 U.S.C. 1396p.

(d) "Long-term care partnership program policy" means a qualified long-term care insurance policy that the commissioner of insurance certifies as meeting the requirements of section 1917(b) of the social security act, 42 U.S.C. 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(e) "Medicaid" means the program of medical assistance operated by

the state under title XIX of the federal social security act, 42 U.S.C. §1396 et seq., and amendments thereto.

New Sec. 14. (a) Subject to subsection (e), the Kansas health policy authority in conjunction with the department of insurance shall establish a long-term care partnership program in Kansas to provide for the financing of long-term care through a combination of private insurance and medicaid. It is the intent of the long-term care partnership program to do all of the following:

(1) Provide incentives for individuals to insure against the costs of providing for their long-term care needs;

(2) provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under medicaid without first being required to substantially exhaust their resources; and

(3) alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(b) An individual who is a beneficiary of a Kansas long-term care partnership program policy is eligible for assistance under the state's medical assistance program using the asset disregard as provided under subsection (e).

(c) The Kansas health policy authority shall pursue reciprocal agreements with other states to extend the asset disregard to Kansas residents who purchased long-term care partnership policies in other states that are compliant with title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and any applicable federal regulations or guidelines.

(d) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (e), shall not be considered when determining any of the following:

(1) Medicaid eligibility;

(2) the amount of any medicaid payment; and

(3) any subsequent recovery by the state of a payment for medical services or long-term care services.

(e) Not later than 180 days after the effective date of this act, the Kansas health policy authority shall apply to the United States centers for medicare and medicaid services for an amendment to the state's medicaid state plan to establish that the assets an individual owns and may retain under medicaid and still qualify for benefits under medicaid at the time the individual applies for benefits is increased dollar-for-dollar for each dollar paid out under the individual's long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

(f) If the long-term care partnership program is discontinued, an in-

dividual who purchased a Kansas long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by title VI, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

(g) The Kansas health policy authority shall provide counseling services under the Kansas long-term care partnership program regarding the partnership program.

(h) The Kansas health policy authority, in consultation with the department of insurance, shall develop a notice to consumers detailing in plain language the pertinent provisions of qualified state long-term care insurance partnership policies as they relate to medicaid eligibility and shall determine the appropriate distribution of the notice. The notice shall be available in a printable form on the department of insurance's website.

(i) The Kansas health policy authority, the department of social and rehabilitation services and the department of insurance shall post, on their respective websites, information on how to access the national clearinghouse established under the federal deficit reduction act of 2005, Public Law 109-171, when the national clearinghouse becomes available to consumers.

New Sec. 15. (a) The commissioner of insurance shall:

(1) Develop requirements to ensure that any individual who sells a qualified long-term care insurance partnership program policy receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care; and

(2) not impose any requirement affecting the terms or benefits of qualified long-term partnership program policies unless the commissioner imposes such a requirement on all long-term policies sold in this state without regard to whether the policy is covered under the partnership or is offered in connection with such partnership.

(b) The issuers of qualified long-term care partnership program policies in this state shall provide regular reports to both the secretary of the department of health and human services in accordance with federal law and regulations and to the Kansas health policy authority and the commissioner of insurance as provided in section 6021 of the federal deficit reduction act of 2005, Public Law 109-171.

New Sec. 16. The Kansas health policy authority, in consultation with the department of social and rehabilitation services and the department of insurance, may promulgate rules and regulations as necessary to implement the partnership program in accordance with the requirements of section 1917(b) of the social security act, 42 U.S.C. 1396p, section 6021 of the federal deficit reduction act of 2005, Public Law 109-171, and applicable federal regulations or guidelines.

New Sec. 17. (a) The legislature finds many residents of this state do not receive medical care and preventive health care because they lack health insurance or because of financial difficulties or cost.

The legislature also finds that many physicians, charity health care facilities and other health care providers in this state would be willing to volunteer medical and allied services without compensation if they were not subject to the high exposure of liability connected with providing these services.

The legislature therefore declares that its intention in enacting this section is to encourage the provision of uncompensated volunteer charity health care in exchange for a limitation on liability for the health care facilities and health care providers who provide those volunteer services.

(b) As used in this section:

(1) "Health care facility" means any clinic or hospital, church or organization whose primary purpose is to sponsor, promote or organize uncompensated health care services for people unable to pay for health care services.

(2) "Health care provider" means a person licensed to practice any branch of the healing arts, a person who holds a temporary permit to practice any branch of the healing arts, a licensed dentist, a person engaged in a postgraduate training program approved by the state board of healing arts, a licensed professional nurse, a licensed practical nurse, a licensed optometrist, a licensed podiatrist or a licensed pharmacist.

(3) "Remuneration or compensation" means: (A) Direct or indirect receipt of any payment by the physician and surgeon, health care facility, other health care professional or organization, on behalf of the patient, including payment or reimbursement under medicare or medicaid or under the state program for the medically indigent on behalf of the patient, and compensation, salary or reimbursement to the health care provider from any source for the health care provider's services or time in volunteering to provide uncompensated health care; and

(B) does not mean any grant or donation to the health care facility used to offset direct costs associated with providing the uncompensated health care such as medical supplies or drugs.

(c) A health care provider who provides health care treatment at or on behalf of a health care facility is not liable in a medical malpractice action if:

(1) The treatment was within the scope of the health care provider's license under this title;

(2) neither the health care provider nor the health care facility received compensation or remuneration for the treatment;

(3) the acts or omissions of the health care provider were not grossly negligent or willful and wanton; and

(4) prior to rendering services, the health care provider disclosed in writing to the patient, or if a minor, to the patient's parent or legal guardian, that the health care provider is providing the services without receiving remuneration or compensation and that in exchange for receiving uncompensated health care, the patient consents to waive any right to sue for professional negligence except for acts or omissions which are grossly negligent or are willful and wanton.

(d) A health care facility which sponsors, promotes or organizes the uncompensated care is not liable in a medical malpractice action for acts and omissions if:

(1) The health care facility meets the requirements in subsection (c)(2);

(2) the acts and omissions of the health care facility were not grossly negligent or willful and wanton; and

(3) the health care facility has posted, in a conspicuous place, a notice that in accordance with this section the health care facility is not liable for any civil damages for acts or omissions except for those acts or omissions that are grossly negligent or are willful and wanton.

(e) Immunity from liability under this section does not extend to the use of general anesthesia or care that requires an overnight stay in a general or special hospital licensed under K.S.A. 65-425 to 65-441, inclusive, and amendments thereto.

New Sec. 18. As used in sections 18 through 20, and amendments thereto:

(a) "Administering carrier" means the insurer or third-party administrator designated in section 20, and amendments thereto.

(b) "Board" means the board of directors of the exchange.

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

(d) "Exchange" means the Kansas insurance exchange association established in section 19, and amendments thereto.

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

(f) "Health maintenance organization" means any organization granted a certificate of authority under the provisions of the health maintenance organization act.

(g) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a group-funded pool, trust or third-party administrator, health care services or benefits other than through an insurer.

(h) "Insurer" means any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance business or long-term care insurance in this state.

(i) "Long-term care insurance" means any insurance policy primarily advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or diagnostic, preventive, therapeutic, rehabilitative, maintenance, custodial, residential or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit medical and hospital service corporations, prepaid health plans, health maintenance organizations, or any similar organization. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(j) "Member" means all insurers and insurance arrangements participating in the exchange.

(k) "Plan of operation" means the plan to create and operate the Kansas insurance exchange association, including articles, bylaws and operating rules, adopted by the board pursuant to section 19, and amendments thereto.

Sec. 19. (a) There is hereby created a nonprofit legal entity to be known as the Kansas insurance exchange association. The Kansas insurance exchange association is created for the purpose of providing residents of the state of Kansas with greater access, choice, renewability and portability of health insurance and long-term care insurance. All insurers and insurance arrangements providing health insurance benefits or long-term insurance benefits in this state may be members of the exchange. The exchange shall operate under a plan of operation established and approved under subsection (b) of this section and shall exercise its powers

through a board of directors established under this section.

(b) (1) The board of directors of the exchange shall be selected by members of the exchange subject to the approval of the commissioner. To select the initial board of directors, and to initially organize the exchange, the commissioner shall give notice to all members in this state of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the exchange for expenses incurred by them as members of the board of directors but shall not otherwise be compensated by the exchange for their services.

(2) The board shall submit to the commissioner a plan of operation for the exchange and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the exchange. The plan of operation shall become effective upon approval in writing by the commissioner. The commissioner shall, after notice and hearing, approve the plan of operation if it is determined to be suitable to assure the fair, reasonable and equitable administration of the exchange. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this section. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.

(3) The plan of operation for the exchange shall, in addition to requirements enumerated elsewhere in this act:

(A) Establish procedures for the listing of health insurance plans, including coverages and rates;

(B) establish procedures for the listing of long-term care insurance, including coverages and rates;

(C) develop and implement a website to allow the comparison of health insurance plans and the comparison of long-term care insurance plans;

(D) establish a procedure for the sharing of data among members of the exchange;

(E) develop and implement a procedure for the collection and transmission to the applicable participating members premium payments or

contributions made by or on behalf of participating individuals, including developing mechanisms to:

(i) Receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

(ii) pool payments from multiple payers and other clearinghouse functions;

(iii) enable participating individuals to pay, in whole or part, for coverage through the exchange by electing to assign to the exchange any federal or state earned income tax credit payments due the participating individual; and

(iv) receive and process any federal or state tax credits or other premium support payments for health insurance, as may be established by law;

(F) establish procedures for the handling and accounting of assets and moneys of the exchange;

(G) select an administering carrier in accordance with section 20, and amendments thereto;

(H) develop and implement a program to publicize the existence of the exchange and to maintain public awareness of the exchange;

(I) encourage use of pretax dollars for health care, such as expanding the use of cafeteria plans under 26 U.S.C. 125;

(J) explore methods to simplify insurance applications, processes and standardize forms and insurance cards, also simplify and standardize provider reimbursement procedures;

(K) determine methods to include medicaid options through the exchange; and

(L) develop procedures for insurance brokers and insurance agents to work through the exchange.

(c) The exchange shall have the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (b), and in addition thereto, the specific authority and duty to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members; and

(3) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the op-

eration of the exchange and any other function within the authority of the exchange.

New Sec. 20. (a) The board shall select an insurer or third-party administrator to administer the exchange. The board shall evaluate bids submitted by interested parties based on criteria established by the board which shall include:

(1) The bidder's proven ability to handle individual accident and health insurance;

(2) an estimate of total charges for administering the exchange; and

(3) the bidder's ability to administer the exchange in a cost efficient manner.

(b) The administering carrier so selected shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service, the board shall invite all interested parties, including the current administering carrier, to submit bids to serve as the administering carrier for the succeeding three-year period. Selection of the administering carrier for the succeeding period shall be made at least six months prior to the end of the current three-year period. The administering carrier shall be paid as provided in the plan of operation.

(c) The administering carrier shall perform all administrative functions relating to the exchange, including:

(1) Accepting payments of premiums from insured persons and remitting such payments to the participating members; and

(2) submitting regular reports to the board regarding the operation of the exchange. The frequency, content and form of the reports shall be as determined by the board.

New Sec. 21. (a) In order to encourage and to expand the use of cafeteria plans authorized by 26 U.S.C. 125, by small employers, there is hereby established the small employer cafeteria plan development program.

(b) Subject to the provisions of appropriations acts and in accordance with the provisions of this act, the secretary of the department of commerce may provide grants to small employers for the purpose of establishing a cafeteria plan authorized by 26 U.S.C. 125. The provisions of this section shall not apply to any small employer who has a cafeteria plan established prior to the effective date of this act.

(c) The secretary of commerce shall develop and implement marketing strategies to ensure that small employers are aware of the state program and to demonstrate the benefits of establishing a cafeteria plan to both the employer and employee.

(d) The secretary of commerce may contract with third party administrators of cafeteria plans authorized by 26 U.S.C. 125, for the purpose

of helping in the development and implementation of the provisions of this section.

(e) There is hereby established in the state treasury the small employer cafeteria plan development program fund. The secretary of commerce shall administer such fund and expenditures from the small employer cafeteria plan development program fund for the purpose of providing grants in accordance with this section. All expenditures from the small employer cafeteria plan development program fund shall be made in accordance with appropriations acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of commerce or the designee of the secretary.

(f) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the small employer cafeteria plan development program fund interest earnings based on:

(1) The average daily balance of moneys in the small employer cafeteria plan development program fund for the preceding month; and

(2) the net earnings rate for the pooled money investment portfolio for the preceding month.

(g) For the purpose of this section "small employer" means any employer that employs 50 or less employees.

(h) The secretary of commerce may adopt rules and regulations to implement the provisions of this section.

(i) The provisions of this section shall expire on July 1, 2009.

New Sec. 22. (a) The secretary of commerce is hereby authorized to make grants or no interest loans for the purpose of financing the initial costs associated with the forming and organizing of associations to assist members of the association to obtain access to quality and affordable health care plans. Such grants or loans may be used to pay for actuarial or feasibility studies.

(b) Such grants and loans shall be made upon such terms and conditions as the secretary of commerce may deem appropriate, except that: (1) Such loans shall be made interest free, and (2) the association shall provide a two-for-one match for such grant or loan. Such grants and loans shall be made from funds credited to the association assistance plan fund.

(c) There is hereby established in the state treasury the association assistance plan fund. The secretary of commerce shall administer such fund and expenditures from the association assistance plan fund for the purpose of providing grants and no interest loans in accordance with this section. All expenditures from the association assistance plan fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the secretary of commerce or the designee of the secretary.

(d) On July 1, 2007, the director of accounts and reports shall transfer $250,000 from the state general fund to the association assistance plan fund.

(e) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the association assistance plan fund interest earnings based on:

(1) The average daily balance of moneys in the association assistance plan fund for the preceding month; and

(2) the net earnings rate for the pooled money investment portfolio for the preceding month.

(f) For the purpose of this section:

(1) "Association" means a small business or an organization of persons having a common interest; and

(2) "small business" means any business that employs 50 or less employees.

(g) The secretary of commerce may adopt rules and regulations to implement the provisions of this section.

New Sec. 23. Notwithstanding any other provision of law:

(a) In order to provide or maintain individual or group health insurance at an affordable rate the commissioner of insurance may waive any rule and regulation or waive any mandated coverages otherwise required by state law.

(b) The commissioner of insurance may waive any rule and regulation or waive any mandated coverages otherwise required by state law if any particular group or geographic area of the state has an uninsured rate in excess of 13%.

New Sec. 24. (a) For the purposes of lowering costs and increasing accessibility of health insurance, the commissioner of insurance is hereby authorized to explore and study the feasibility of creating and entering into a regional insurance pool.

(b) The commissioner of insurance shall make a report to the legislature no later than the convening of the 2008 Kansas legislature.

New Sec. 25. (a) On or before November 1, 2007, the Kansas health policy authority shall develop and deliver to the governor, the joint committee on health policy oversight, the speaker of the house of representatives, the majority leader of the house of representatives, the minority leader of the house of representatives, the president of the senate, the majority leader of the senate and the minority leader of the senate, health care finance reform options for enactment by the legislature during the 2008 regular session, including an analysis of a Kansas health care insurance connector, a model for a voluntary health insurance connector, and draft legislation for the proposed health care finance reform options. In developing such options, the Kansas health policy authority shall solicit

and consider information and recommendations from advisory committees established under subsection (c) of K.S.A. 75-7403, and amendments thereto, and shall advise and consult with the joint committee on health policy oversight regularly and on a continuing basis. These reports should take into account and build upon the reforms included throughout this act. The Kansas health policy authority shall develop and analyze other pertinent initiatives and policies designed to increase access to affordable health insurance and to otherwise promote health in developing the options.

(b) The Kansas health policy authority shall analyze and develop health care finance reform options with the goals of (1) financing health care and health promotion in a manner that is equitable, seamless and sustainable for consumers, providers, purchasers and government, (2) promoting market-based solutions that encourage fiscal and individual responsibility, (3) protecting the health care safety net in the development of such options, (4) facilitating pooling and purchasing of health insurance, and facilitating access to health insurance by small businesses and individuals.

(c) The Kansas health policy authority shall identify and analyze policies that are designed to increase portability, to increase individual ownership of health care policies, to utilize pre-tax dollars for the purchase of health insurance, and to expand consumer responsibility for making health care decisions.

(d) The Kansas health policy authority with the advice of the joint committee on health policy oversight shall obtain economic and actuarial analyses by an entity or entities that are recognized as having specific experience in the subject matter of all health care finance reform options proposed under subsection (a) to determine (1) the economic impact of proposed reforms on consumers, providers, purchasers, businesses and government and (2) the number of uninsured Kansans who have the potential to receive coverage as a result of the options proposed under subsection (a).

(e) In collaboration with the commissioner of insurance, the joint committee on health policy oversight, the Kansas health policy authority shall analyze the potential for reinsurance and state subsidies for reinsurance as mechanisms to reduce premium volatility in the small group and individual insurance market, to increase predictability in premium trends, to lower costs and to increase coverage as a component of the options proposed under subsection (a).

(f) In performing the tasks in this section, the Kansas health policy authority shall consider:

(1) That the house of representatives is committed to improving the health of all Kansans with a vision to expand private health care and

private health insurance while decreasing the number of uninsured and those dependent on government programs, guided by principles that, whenever possible: (A) Preserve and stabilize the health care system safety net; (B) use market forces to expand private health insurance coverage, limit costs, improve quality and guarantee long term health insurance stability for all Kansans; (C) strengthen the pluralistic, world-class health system of Kansas; (D) expand private sector health care and insurance rather than rely on government assistance; (E) do not rely on individual or employer mandates or new taxes; (F) minimize the number and impact of uninsured; and (G) carefully craft programs that emphasize wellness and the health care needs of Kansans;

(2) that the legislature, the commissioner of insurance, the Kansas health policy authority, other agencies of the executive branch of state government and the private sector are encouraged to work together to expand the private insurance market by increasing the number of private insurance plans; promoting policies which provide affordability, portability, renewability and choice and increasing health savings accounts (HSAs); and enabling Kansans to use pretax dollars to save at least 15% on health care;

(3) that the legislature, the Kansas health policy authority, other agencies of the executive branch of state government and the United States department of health and human services are encouraged to partner together to modernize government financed health care using the national governors association and federal recommendations, market forces and the experience of other states to carefully redesign the Kansas state medicaid plan to give a wide choice of providers and contractors, multiple HSAs and benefit packages that target different health problems and health opportunity accounts that reward healthy initiatives and personal responsibility; that the Kansas health policy authority is urged to establish a task force to partner with the center for medicare and medicaid services and the joint committee on health policy oversight to expedite Kansas state medicaid plan amendments and waivers to prevent waste, fraud and abuse, modernize senior and pediatric care and stabilize multiyear funding and to advance the initiatives listed above;

(4) that the legislature, the commissioner of insurance, the Kansas health policy authority, other agencies of the executive branch of state government, the private sector and the United States department of health and human services are encouraged to implement policies to transition Kansans from the uninsured and medicaid rolls to private health insurance through multiple targeted programs, including, but not limited to, premium assistance, tax credits, programs for individuals between jobs, family plans, small business plans and plans tailored to ethnic and cultural groups;

(5) that the legislature, agencies of the executive branch of state government and the private sector are urged to collaborate to strengthen safety net clinics and emergency rooms and encourage more providers to expand charity care; and

(6) that long term stability of state financial support for the health care and insurance system be improved through a private foundation or trust fund into which one time windfalls, asset sales, public and private grants and other revenues are paid and the earnings on such revenues be available to the state to invest in health initiatives listed above.

New Sec. 26. The speaker of the house of representatives may appoint an interim committee or committees to examine policy changes to:

(a) Increase number of commercially insured Kansans;

(b) improve competitiveness in the insurance industry to improve affordability and accessibility for Kansas consumers;

(c) examine laws and regulations governing the types of plans available to Kansans and their effect on affordability, accessibility, renewability and portability of such policies;

(d) study the role of short term gap insurance for those in transition between jobs;

(e) study transparency and methods to have actual market pricing of health services and how to eliminate confusing fee schedules;

(f) examine the data requirements on the health industry made by the department of health and environment, the commissioner of insurance and the Kansas health policy authority;

(g) examine if the uninsurable pool needs to be modified;

(h) examine pooling arrangements and other requirements to encourage affordability;

(i) examine role of secondary insurance and other changes for long-term stability;

(j) consider methods to increase the number of Kansans with long-term care insurance; and

(k) related issues as determined by the speaker.

Sec. 27. K.S.A. 2006 Supp. 39-709 is hereby amended to read as follows: 39-709. (a) *General eligibility requirements for assistance for which federal moneys are expended.* Subject to the additional requirements below, assistance in accordance with plans under which federal moneys are expended may be granted to any needy person who:

(1) Has insufficient income or resources to provide a reasonable subsistence compatible with decency and health. Where a husband and wife are living together, the combined income or resources of both shall be considered in determining the eligibility of either or both for such assistance unless otherwise prohibited by law. The secretary, in determining need of any applicant for or recipient of assistance shall not take into

account the financial responsibility of any individual for any applicant or recipient of assistance unless such applicant or recipient is such individual's spouse or such individual's minor child or minor stepchild if the stepchild is living with such individual. The secretary in determining need of an individual may provide such income and resource exemptions as may be permitted by federal law. For purposes of eligibility for aid for families with dependent children, for food stamp assistance and for any other assistance provided through the department of social and rehabilitation services under which federal moneys are expended, the secretary of social and rehabilitation services shall consider one motor vehicle owned by the applicant for assistance, regardless of the value of such vehicle, as exempt personal property and shall consider any equity in any additional motor vehicle owned by the applicant for assistance to be a nonexempt resource of the applicant for assistance.

(2) Is a citizen of the United States or is an alien lawfully admitted to the United States and who is residing in the state of Kansas.

(b) *Assistance to families with dependent children.* Assistance may be granted under this act to any dependent child, or relative, subject to the general eligibility requirements as set out in subsection (a), who resides in the state of Kansas or whose parent or other relative with whom the child is living resides in the state of Kansas. Such assistance shall be known as aid to families with dependent children. Where husband and wife are living together both shall register for work under the program requirements for aid to families with dependent children in accordance with criteria and guidelines prescribed by rules and regulations of the secretary.

(c) *Aid to families with dependent children; assignment of support rights and limited power of attorney.* By applying for or receiving aid to families with dependent children such applicant or recipient shall be deemed to have assigned to the secretary on behalf of the state any accrued, present or future rights to support from any other person such applicant may have in such person's own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid. In any case in which an order for child support has been established and the legal custodian and obligee under the order surrenders physical custody of the child to a caretaker relative without obtaining a modification of legal custody and support rights on behalf of the child are assigned pursuant to this section, the surrender of physical custody and the assignment shall transfer, by operation of law, the child's support rights under the order to the secretary on behalf of the state. Such assignment shall be of all accrued, present or future rights to support of the child surrendered to the caretaker relative. The assignment of support rights shall automatically become effective upon the date of approval for or

receipt of such aid without the requirement that any document be signed by the applicant, recipient or obligee. By applying for or receiving aid to families with dependent children, or by surrendering physical custody of a child to a caretaker relative who is an applicant or recipient of such assistance on the child's behalf, the applicant, recipient or obligee is also deemed to have appointed the secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary in behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the secretary approves the application for aid and shall remain in effect until the assignment of support rights has been terminated in full.

(d) *Eligibility requirements for general assistance, the cost of which is not shared by the federal government.* (1) General assistance may be granted to eligible persons who do not qualify for financial assistance in a program in which the federal government participates and who satisfy the additional requirements prescribed by or under this subsection (d).

(A) To qualify for general assistance in any form a needy person must have insufficient income or resources to provide a reasonable subsistence compatible with decency and health and, except as provided for transitional assistance, be a member of a family in which a minor child or a pregnant woman resides or be unable to engage in employment. The secretary shall adopt rules and regulations prescribing criteria for establishing when a minor child may be considered to be living with a family and whether a person is able to engage in employment, including such factors as age or physical or mental condition. Eligibility for general assistance, other than transitional assistance, is limited to families in which a minor child or a pregnant woman resides or to an adult or family in which all legally responsible family members are unable to engage in employment. Where a husband and wife are living together the combined income or resources of both shall be considered in determining the eligibility of either or both for such assistance unless otherwise prohibited by law. The secretary in determining need of any applicant for or recipient of general assistance shall not take into account the financial responsibility of any individual for any applicant or recipient of general assistance unless such applicant or recipient is such individual's spouse or such individual's minor child or a minor stepchild if the stepchild is living with such individual. In determining the need of an individual, the secretary may provide for income and resource exemptions.

(B) To qualify for general assistance in any form a needy person must be a citizen of the United States or an alien lawfully admitted to the United States and must be residing in the state of Kansas.

(2) General assistance in the form of transitional assistance may be granted to eligible persons who do not qualify for financial assistance in a program in which the federal government participates and who satisfy the additional requirements prescribed by or under this subsection (d), but who do not meet the criteria prescribed by rules and regulations of the secretary relating to inability to engage in employment or are not a member of a family in which a minor or a pregnant woman resides.

(3) In addition to the other requirements prescribed under this subsection (d), the secretary shall adopt rules and regulations which establish community work experience program requirements for eligibility for the receipt of general assistance in any form and which establish penalties to be imposed when a work assignment under a community work experience program requirement is not completed without good cause. The secretary may adopt rules and regulations establishing exemptions from any such community work experience program requirements. A first time failure to complete such a work assignment requirement shall result in ineligibility to receive general assistance for a period fixed by such rules and regulations of not more than three calendar months. A subsequent failure to complete such a work assignment requirement shall result in a period fixed by such rules and regulations of ineligibility of not more than six calendar months.

(4) If any person is found guilty of the crime of theft under the provisions of K.S.A. 39-720, and amendments thereto, such person shall thereby become forever ineligible to receive any form of general assistance under the provisions of this subsection (d) unless the conviction is the person's first conviction under the provisions of K.S.A. 39-720, and amendments thereto, or the law of any other state concerning welfare fraud. First time offenders convicted of a misdemeanor under the provisions of such statute shall become ineligible to receive any form of general assistance for a period of 12 calendar months from the date of conviction. First time offenders convicted of a felony under the provisions of such statute shall become ineligible to receive any form of general assistance for a period of 60 calendar months from the date of conviction. If any person is found guilty by a court of competent jurisdiction of any state other than the state of Kansas of a crime involving welfare fraud, such person shall thereby become forever ineligible to receive any form of general assistance under the provisions of this subsection (d) unless the conviction is the person's first conviction under the law of any other state concerning welfare fraud. First time offenders convicted of a misdemeanor under the law of any other state concerning welfare fraud shall become ineligible to receive any form of general assistance for a period of 12 calendar months from the date of conviction. First time offenders convicted of a felony under the law of any other state concerning welfare

fraud shall become ineligible to receive any form of general assistance for a period of 60 calendar months from the date of conviction.

(e) *Requirements for medical assistance for which federal moneys or state moneys or both are expended.* (1) When the ~~secretary~~ *Kansas health policy authority* has adopted a medical care plan under which federal moneys or state moneys or both are expended, medical assistance in accordance with such plan shall be granted to any person who is a citizen of the United States or who is an alien lawfully admitted to the United States and who is residing in the state of Kansas, whose resources and income do not exceed the levels prescribed by the ~~secretary~~ *Kansas health policy authority*. In determining the need of an individual, the ~~secretary~~ *Kansas health policy authority* may provide for income and resource exemptions and protected income and resource levels *and shall disregard certain assets under subsection (d) and (e) of new section 14, and amendments thereto, when appropriate*. Resources from inheritance shall be counted. A disclaimer of an inheritance pursuant to K.S.A. 59-2291, and amendments thereto, shall constitute a transfer of resources. The ~~secretary~~ *Kansas health policy authority* shall exempt principal and interest held in irrevocable trust pursuant to subsection (c) of K.S.A. 16-303, and amendments thereto, from the eligibility requirements of applicants for and recipients of medical assistance. Such assistance shall be known as medical assistance.

(2) For the purposes of medical assistance eligibility determinations on or after July 1, 2004, if an applicant or recipient owns property in joint tenancy with some other party and the applicant or recipient of medical assistance has restricted or conditioned their interest in such property to a specific and discrete property interest less than 100%, then such designation will cause the full value of the property to be considered an available resource to the applicant or recipient.

(3) Resources from trusts shall be considered when determining eligibility of a trust beneficiary for medical assistance. Medical assistance is to be secondary to all resources, including trusts, that may be available to an applicant or recipient of medical assistance. If a trust has discretionary language, the trust shall be considered to be an available resource to the extent, using the full extent of discretion, the trustee may make any of the income or principal available to the applicant or recipient of medical assistance. Any such discretionary trust shall be considered an available resource unless: (1) The trust is funded exclusively from resources of a person who, at the time of creation of the trust, owed no duty of support to the applicant or recipient; and (2) the trust contains specific contemporaneous language that states an intent that the trust be supplemental to public assistance and the trust makes specific reference to medicaid, medical assistance or title XIX of the social security act.

(4) (A) When an applicant or recipient of medical assistance is a party to a contract, agreement or accord for personal services being provided by a nonlicensed individual or provider and such contract, agreement or accord involves health and welfare monitoring, pharmacy assistance, case management, communication with medical, health or other professionals, or other activities related to home health care, long term care, medical assistance benefits, or other related issues, any moneys paid under such contract, agreement or accord shall be considered to be an available resource unless the following restrictions are met: (i) The contract, agreement or accord must be in writing and executed prior to any services being provided; (ii) the moneys paid are in direct relationship with the fair market value of such services being provided by similarly situated and trained nonlicensed individuals; (iii) if no similarly situated nonlicensed individuals or situations can be found, the value of services will be based on federal hourly minimum wage standards; (iv) such individual providing the services will report all receipts of moneys as income to the appropriate state and federal governmental revenue agencies; (v) any amounts due under such contract, agreement or accord shall be paid after the services are rendered; (vi) the applicant or recipient shall have the power to revoke the contract, agreement or accord; and (vii) upon the death of the applicant or recipient, the contract, agreement or accord ceases.

(B) When an applicant or recipient of medical assistance is a party to a written contract for personal services being provided by a licensed health professional or facility and such contract involves health and welfare monitoring, pharmacy assistance, case management, communication with medical, health or other professionals, or other activities related to home health care, long term care, medical assistance benefits or other related issues, any moneys paid in advance of receipt of services for such contracts shall be considered to be an available resource.

(f) *Eligibility for medical assistance of resident receiving medical care outside state.* A person who is receiving medical care including long-term care outside of Kansas whose health would be endangered by the postponement of medical care until return to the state or by travel to return to Kansas, may be determined eligible for medical assistance if such individual is a resident of Kansas and all other eligibility factors are met. Persons who are receiving medical care on an ongoing basis in a long-term medical care facility in a state other than Kansas and who do not return to a care facility in Kansas when they are able to do so, shall no longer be eligible to receive assistance in Kansas unless such medical care is not available in a comparable facility or program providing such medical care in Kansas. For persons who are minors or who are under guardianship, the actions of the parent or guardian shall be deemed to be the actions of the child or ward in determining whether or not the person is

remaining outside the state voluntarily.

(g) *Medical assistance; assignment of rights to medical support and limited power of attorney; recovery from estates of deceased recipients.* (1) Except as otherwise provided in K.S.A. 39-786 and 39-787, and amendments thereto, or as otherwise authorized on and after September 30, 1989, under section 303 and amendments thereto of the federal medicare catastrophic coverage act of 1988, whichever is applicable, by applying for or receiving medical assistance under a medical care plan in which federal funds are expended, any accrued, present or future rights to support and any rights to payment for medical care from a third party of an applicant or recipient and any other family member for whom the applicant is applying shall be deemed to have been assigned to the ~~secretary~~ *Kansas health policy authority* on behalf of the state. The assignment shall automatically become effective upon the date of approval for such assistance without the requirement that any document be signed by the applicant or recipient. By applying for or receiving medical assistance the applicant or recipient is also deemed to have appointed the ~~secretary~~ *Kansas health policy authority*, or the ~~secretary's~~ *Kansas health policy authority's* designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments, representing payments received by the ~~secretary in~~ *Kansas health policy authority on* behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the ~~secretary~~ *Kansas health policy authority* approves the application for assistance and shall remain in effect until the assignment has been terminated in full. The assignment of any rights to payment for medical care from a third party under this subsection shall not prohibit a health care provider from directly billing an insurance carrier for services rendered if the provider has not submitted a claim covering such services to the ~~secretary~~ *Kansas health policy authority* for payment. Support amounts collected on behalf of persons whose rights to support are assigned to the secretary only under this subsection and no other shall be distributed pursuant to subsection (d) of K.S.A. 39-756, and amendments thereto, except that any amounts designated as medical support shall be retained by the ~~secretary~~ *Kansas health policy authority* for repayment of the unreimbursed portion of assistance. Amounts collected pursuant to the assignment of rights to payment for medical care from a third party shall also be retained by the ~~secretary~~ *Kansas health policy authority* for repayment of the unreimbursed portion of assistance.

(2) The amount of any medical assistance paid after June 30, 1992, under the provisions of subsection (e) is (A) a claim against the property or any interest therein*, disregarding certain assets under subsections (d)*

and (e) of section 14, and amendments thereto, if appropriate, belonging to and a part of the estate of any deceased recipient or, if there is no estate, the estate of the surviving spouse, if any, shall be charged for such medical assistance paid to either or both, and (B) a claim against any funds of such recipient or spouse in any account under K.S.A. 9-1215, 9-1216, 17-2263, 17-2264, 17-5828 or 17-5829, and amendments thereto. There shall be no recovery of medical assistance correctly paid to or on behalf of an individual under subsection (e) except after the death of the surviving spouse of the individual, if any, and only at a time when the individual has no surviving child who is under 21 years of age or is blind or permanently and totally disabled. Transfers of real or personal property by recipients of medical assistance without adequate consideration are voidable and may be set aside. Except where there is a surviving spouse, or a surviving child who is under 21 years of age or is blind or permanently and totally disabled, the amount of any medical assistance paid under subsection (e) is a claim against the estate in any guardianship or conservatorship proceeding. The monetary value of any benefits received by the recipient of such medical assistance under long-term care insurance, as defined by K.S.A. 40-2227, and amendments thereto, shall be a credit against the amount of the claim provided for such medical assistance under this subsection (g). The ~~secretary~~ *Kansas health policy authority* is authorized to enforce each claim provided for under this subsection (g). The ~~secretary~~ *Kansas health policy authority* shall not be required to pursue every claim, but is granted discretion to determine which claims to pursue. All moneys received by the ~~secretary~~ *Kansas health policy authority* from claims under this subsection (g) shall be deposited in the social welfare fund. The ~~secretary~~ *Kansas health policy authority* may adopt rules and regulations for the implementation and administration of the medical assistance recovery program under this subsection (g).

(3) By applying for or receiving medical assistance under the provisions of article 7 of chapter 39 of the Kansas Statutes Annotated, such individual or such individual's agent, fiduciary, guardian[,] conservator, representative payee or other person acting on behalf of the individual consents to the following definitions of estate and the results therefrom:

(A) If an individual receives any medical assistance before July 1, 2004, pursuant to article 7 of chapter 39 of the Kansas Statutes Annotated, which forms the basis for a claim under subsection (g)(2), such claim is limited to the individual's probatable estate as defined by applicable law; and

(B) if an individual receives any medical assistance on or after July 1, 2004, pursuant to article 7 of chapter 39 of the Kansas Statutes Annotated, which forms the basis for a claim under subsection (g)(2), such claim shall apply to the individual's medical assistance estate. The medical assistance

estate is defined as including all real and personal property and other assets in which the deceased individual had any legal title or interest immediately before or at the time of death to the extent of that interest or title. The medical assistance estate includes, without limitation assets conveyed to a survivor, heir or assign of the deceased recipient through joint tenancy, tenancy in common, survivorship, transfer-on-death deed, payable-on-death contract, life estate, trust, annuities or similar arrangement.

(4) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* or the ~~secretary's~~ *authority's* designee is authorized to file and enforce a lien against the real property of a recipient of medical assistance in certain situations, subject to all prior liens of record. The lien must be filed in the office of the register of deeds of the county where the real property is located and must contain the legal description of all real property in the county subject to the lien. This lien is for payments of medical assistance made by the ~~department of social and rehabilitation services~~ *Kansas health policy authority* to the recipient who is an inpatient in a nursing home or other medical institution. Such lien may be filed only after notice and an opportunity for a hearing has been given. Such lien may be enforced only upon competent medical testimony that the recipient cannot reasonably be expected to be discharged and returned home. A six-month period of compensated inpatient care at a nursing home, nursing homes or other medical institution shall constitute a determination by the ~~department of social and rehabilitation services~~ *Kansas health policy authority* that the recipient cannot reasonably be expected to be discharged and returned home. To return home means the recipient leaves the nursing or medical facility and resides in the home on which the lien has been placed for a period of at least 90 days without being readmitted as an inpatient to a nursing or medical facility. The amount of the lien shall be for the amount of assistance paid by the ~~department of social and rehabilitation services~~ *Kansas health policy authority* after the expiration of six months from the date the recipient became eligible for compensated inpatient care at a nursing home, nursing homes or other medical institution until the time of the filing of the lien and for any amount paid thereafter for such medical assistance to the recipient. *The amount of the lien shall not include assets to be disregarded under subsections (d) and (e) of section 14, and amendments thereto, if appropriate.*

(5) The lien filed by the ~~secretary~~ *Kansas health policy authority* or the ~~secretary's~~ *authority's* designee for medical assistance correctly received may be enforced before or after the death of the recipient by the filing of an action to foreclose such lien in the Kansas district court or through an estate probate court action in the county where the real prop-

erty of the recipient is located. However, it may be enforced only:

(A) After the death of the surviving spouse of the recipient;

(B) when there is no child of the recipient, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the recipient, natural or adopted, who is blind or disabled residing in the home; or

(D) when no brother or sister of the recipient is lawfully residing in the home, who has resided there for at least one year immediately before the date of the recipient's admission to the nursing or medical facility, and has resided there on a continuous basis since that time.

(6) The lien remains on the property even after a transfer of the title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The recipient, the heirs, personal representative or assigns of the recipient may discharge such lien at any time by paying the amount of the lien to the ~~secretary~~ *Kansas health policy authority* or the ~~secretary's~~ *authority's* designee;

(B) the lien is terminated by foreclosure of prior lien of record or settlement action taken in lieu of foreclosure;

(C) the value of the real property is consumed by the lien, at which time the ~~secretary~~ *Kansas health policy authority* or the ~~secretary's~~ *authority's* designee may force the sale for the real property to satisfy the lien; or

(D) after a lien is filed against the real property, it will be dissolved if the recipient leaves the nursing or medical facility and resides in the property to which the lien is attached for a period of more than 90 days without being readmitted as an inpatient to a nursing or medical facility, even though there may have been no reasonable expectation that this would occur. If the recipient is readmitted to a nursing or medical facility during this period, and does return home after being released, another 90 days must be completed before the lien can be dissolved.

(7) If the ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* or the ~~secretary's~~ *authority's* designee has not filed an action to foreclose the lien in the Kansas district court in the county where the real property is located within 10 years from the date of the filing of the lien, then the lien shall become dormant, and shall cease to operate as a lien on the real estate of the recipient. Such dormant lien may be revived in the same manner as a dormant judgment lien is revived under K.S.A. 60-2403 et seq., and amendments thereto.

(h) *Placement under code for care of children or revised Kansas juvenile justice code; assignment of support rights and limited power of attorney.* In any case in which the secretary of social and rehabilitation services pays for the expenses of care and custody of a child pursuant to

~~K.S.A. 38-1501~~ *K.S.A. 2006 Supp. 38-2201* et seq. or K.S.A. 2006 Supp. 38-2301 et seq., and amendments thereto, including the expenses of any foster care placement, an assignment of all past, present and future support rights of the child in custody possessed by either parent or other person entitled to receive support payments for the child is, by operation of law, conveyed to the secretary. Such assignment shall become effective upon placement of a child in the custody of the secretary or upon payment of the expenses of care and custody of a child by the secretary without the requirement that any document be signed by the parent or other person entitled to receive support payments for the child. When the secretary pays for the expenses of care and custody of a child or a child is placed in the custody of the secretary, the parent or other person entitled to receive support payments for the child is also deemed to have appointed the secretary, or the secretary's designee, as attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary on behalf of the child. This limited power of attorney shall be effective from the date the assignment to support rights becomes effective and shall remain in effect until the assignment of support rights has been terminated in full.

(i) No person who voluntarily quits employment or who is fired from employment due to gross misconduct as defined by rules and regulations of the secretary or who is a fugitive from justice by reason of a felony conviction or charge shall be eligible to receive public assistance benefits in this state. Any recipient of public assistance who fails to timely comply with monthly reporting requirements under criteria and guidelines prescribed by rules and regulations of the secretary shall be subject to a penalty established by the secretary by rules and regulations.

(j) If the applicant or recipient of aid to families with dependent children is a mother of the dependent child, as a condition of the mother's eligibility for aid to families with dependent children the mother shall identify by name and, if known, by current address the father of the dependent child except that the secretary may adopt by rules and regulations exceptions to this requirement in cases of undue hardship. Any recipient of aid to families with dependent children who fails to cooperate with requirements relating to child support enforcement under criteria and guidelines prescribed by rules and regulations of the secretary shall be subject to a penalty established by the secretary by rules and regulations which penalty shall progress to ineligibility for the family after three months of noncooperation.

(k) By applying for or receiving child care benefits or food stamps, the applicant or recipient shall be deemed to have assigned, pursuant to K.S.A. 39-756 and amendments thereto, to the secretary on behalf of the

state only accrued, present or future rights to support from any other person such applicant may have in such person's own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid. The assignment of support rights shall automatically become effective upon the date of approval for or receipt of such aid without the requirement that any document be signed by the applicant or recipient. By applying for or receiving child care benefits or food stamps, the applicant or recipient is also deemed to have appointed the secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary in behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the secretary approves the application for aid and shall remain in effect until the assignment of support rights has been terminated in full. An applicant or recipient who has assigned support rights to the secretary pursuant to this subsection shall cooperate in establishing and enforcing support obligations to the same extent required of applicants for or recipients of aid to families with dependent children.

Sec. 28. K.S.A. 39-785 is hereby amended to read as follows: 39-785. As used in K.S.A. 21-3605, 39-709 and K.S.A. 39-785 to 39-790, inclusive and amendments thereto:

(a) "Adult care home" means a nursing facility licensed under the adult care home licensure act.

(b) "Excess shelter allowance" means, for the applicant or recipient's spouse, the amount by which the sum of (1) the spouse's expense for rent or mortgage payment, including principal and interest, taxes and insurance and, in the case of a condominium or cooperative, required maintenance charges excluding utilities, for the spouse's principal residence, and (2) the standard utility allowance under section 5(e) of the food stamp act of 1977, exceeds 30% of the maximum amount of income allowed under K.S.A. 39-787 and amendments thereto.

(c) "Home and community based services" means those services provided under the state medical assistance program under waivers as defined in title XIX of the federal social security act in accordance with the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto to recipients who would require admission to an adult care home if such services were not otherwise provided.

(d) "Income" means earned income and unearned income as defined under the state medical assistance program in accordance with the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto to determine eligibility of applicants for medical assistance.

(e) "Institution" means an adult care home or a long-term care unit

of a medical care facility.

(f) "Medical assistance" has the meaning provided under K.S.A. 39-702 and amendments thereto.

(g) "Qualified applicant" means a person who (1) applies for medical assistance and (2) is receiving long-term care in an institution or would be eligible for home and community based services if receiving medical assistance.

(h) "Qualified recipient" means a person who (1) receives medical assistance and (2) is receiving long-term care in an institution or is receiving home and community based services.

(i) "Resources" means cash or other liquid assets or any real or personal property that an individual or spouse owns and could convert to cash to be used for such individual's support and maintenance *except for assets to be disregarded under subsections (d) and (e) of section 14, and amendments thereto, if appropriate*. If the individual has the right, authority or power to liquidate the property, or such individual's share of the property, it is a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual or spouse.

(j) "Secretary" means the secretary of social and rehabilitation services.

(k) "Exempt income" means income which is not considered in determining eligibility for medical assistance under the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto.

(l) "Nonexempt income" means income which is considered in determining eligibility for medical assistance under the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto.

(m) "Exempt resources" means resources which are not considered in determining eligibility for medical assistance under the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto.

(n) "Nonexempt resources" means resources which are considered in determining eligibility for medical assistance under the plan adopted under subsection (s) of K.S.A. 39-708c and amendments thereto.

(o) "Long-term care" means care which exceeds or is projected to exceed three months, including the month care begins.

Sec. 29. K.S.A. 2006 Supp. 40-19c06 is hereby amended to read as follows: 40-19c06. (a) No subscription agreement, except as provided in subsection (d), between a corporation organized under the nonprofit medical and hospital service corporation act and a subscriber, shall entitle more than one person to benefits, except that a "family subscription agreement" may be issued, at an established subscription charge, to a husband and wife, or husband, wife, and their dependent child or children and any other person dependent upon the subscriber. Only the subscriber must be named in the subscription agreement.

(b) Every subscription agreement entered into by any such corporation with any subscriber shall be in writing and a certificate stating the terms and conditions shall be furnished to the subscriber to be kept by the subscriber. No such certificate form shall be made, issued or delivered in this state unless it contains the following provisions: (1) A statement of the nature of the benefits to be furnished and the period during which they will be furnished, and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified; (2) a statement of the terms and conditions, if any, upon which the subscription agreement may be canceled or otherwise terminated at the option of either party; (3) a statement that the subscription agreement includes the endorsements and attached papers, if any, and contains the entire contract; (4) a statement that no statement by the subscriber in the application for a subscription agreement shall avoid the subscription agreement or be used in any legal proceeding, unless such application or an exact copy is included in or attached to such subscription agreement, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the subscription agreement or waive any of its provisions; (5) a statement that if the subscriber defaults in making any payments under the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription agreement but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance; (6) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall not be less than 10 days; and (7) if applicable, a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber may be entitled to in such kinds of hospitals. The subscriber shall be entitled to benefits in any nonparticipating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals. The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers.

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

shall be a brief description of the subscription agreement on the first page and on its filing back.

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

(e) (1) Any group subscription agreement issued pursuant to subsection (d) shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with respect to an insured class, and who has been continuously insured under the group subscription agreement or under any group policy or subscription agreement 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~~ *18* months and at the end of such ~~six-month~~ *eighteen-month* period of continuation, such employee or member or such employee's or member's covered dependents shall be entitled to obtain, at the employee's, member's or dependent's option either:

(A) A converted subscription agreement providing coverage equal to 80% of that afforded under the group subscription agreement for basic hospital, surgical and medical benefits. Persons selecting this option shall also be entitled to obtain major medical expense coverage which will provide hospital, medical and surgical expense benefits to an aggregate maximum of not less than $50,000. The major medical expense coverage may be subject to a copayment by the covered person of not more than 20% of covered charges and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis or a combination of such bases of not more than $500 per person subject to a maximum annual deductible of $750 per family; or

(B) a subscription agreement which imposes a deductible of not less than $1,000 per subscriber and not less than $2,000 per family and subjects the covered person to a copayment of not more than 20% of covered charges with a $1,000 maximum copayment per subscriber and $2,000 maximum copayment per family per contract year and providing a lifetime maximum benefit of not less than $1,000,000.

(2) The requirements imposed by this subsection (e) shall not apply to a group subscription agreement which provides benefits for specific diseases or for accidental injuries only or any group subscription agreement 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 any employee or member or such employee's or member's covered dependents whose termination of insurance under the group subscription agreement occurred because:

(A) Such person 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;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or 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);

(C) 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; or

(D) 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. 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 subscription agreement. 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 (e) in lieu of the right to continue group coverage.

(3) Written application for the converted subscription agreement shall be made and the first premium paid to the insurer not later than 31 days after termination of the group coverage and shall become effective the day following the termination of insurance under the group subscription agreement. In addition, the converted subscription agreement shall be subject to the provisions contained in paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (10), (13), (14), (15), (16), (17), (18), (19), and (20) of sub-

section (j) of K.S.A. 40-2209, and amendments thereto.

Sec. 30. K.S.A. 2006 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 organi-

zation, (I) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or a similar health benefits risk pool of another state, (J) a health plan offered under chapter 89 of title 5, United States code, (K) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e), or (L) a group subject to K.S.A. 12-2616 et seq. and amendments thereto which provided hospital, medical and surgical expense benefits within 63 days prior to the effective date of coverage with no gap in coverage. A group policy shall credit the periods of prior coverage specified in subsection (a)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

group policy or new employees or members who may become eligible for such coverage.

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

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

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

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

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

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

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least two employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual

proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

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

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

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

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

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a

group sickness and accident policy or contract.

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

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

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

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

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

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

group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of ~~six~~ *18* 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~~ *eighteen-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~~ *eighteen-month* continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

group policy from which conversion is made.

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

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

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

(i) The smaller of the following amounts:

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

(ii) The smaller of the following amounts:

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

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

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

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

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

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

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

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

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

(14) In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of employment or membership.

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

(16) Subject to the conditions set forth above, the continuation and

conversion privileges shall also be available:

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

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

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

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

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

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

(20) The insurer shall give the employee or member and such employee's or member's covered dependents: (A) Reasonable notice of the right to convert at least once during the ~~six-month~~ *eighteen-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. 31. K.S.A. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy or certificate of accident and sickness insurance providing hospital, medical or surgical expense benefits shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto has been filed with the commissioner of insurance.

(c) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof*, except that if an insurer becomes a member of the exchange under section 20, and amendments thereto, each such policy, rider or endorsement issued or delivered in this state shall be effective on filing, or any subsequent date selected by the insurer, unless the commissioner disapproves such policy, rider or endorsement within 30 days after filing.*

(d) The commissioner may, within 30 days after the filing of any form, disapprove such form: (1) If, in the case of any form required to be filed pursuant to subsection (a), the benefits provided therein are unreasonable in relation to the premium charged; or (2) if, in the case of any form required to be filed pursuant to subsection (a) or (b), it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. If the commissioner notifies the insurer which has filed any such form that it does not comply with the provisions of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, it shall be unlawful thereafter for such insurer to issue such form or use it in connection with any policy. In such notice the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within 20 days after request in writing by the insurer.

(e) (1) Any risk classifications, premium rates, rating formulae, and all modifications thereof applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket sickness and accident policies providing hospital, medical or surgical expense benefits issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals

eligible for participation in a group, or establish rating classifications within a group that are based on medical conditions. In no event shall the rates charged to any group to which this subsection applies increase by more than 75% during any annual period unless the insurer can clearly document a material and significant change in the risk characteristics of the group.

(2) All rates for sickness and accident insurance providing hospital, medical or surgical expense benefits covering Kansas residents shall be made in accordance with the following provisions and due consideration shall be given to: (A) Past and prospective loss experience; (B) past and prospective expenses; (C) adequate contingency reserves; and (D) all other relevant factors within and without the state.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

(f) The provisions of subsection (e) shall not apply to any medicare supplement policy as defined by the commissioner pursuant to rule and regulation, any policy of long-term care insurance as defined by K.S.A. 40-2227 and amendments thereto, any specified disease, specified accident or accident only coverage, credit insurance, hospital confinement indemnity or any disability income protection policy.

(g) The commissioner may at any time, after a hearing of which not less than 20 days' written notice shall be given to the insurer, withdraw approval of any such form or disapprove any rate filed in accordance with subsection (a) in the event the commissioner finds such filing no longer meets the requirements of this section or of article 22 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto. It shall be unlawful for the insurer to issue such form or use it in connection with any policy after the effective date of such withdrawal of approval.

(h) Violations of subsection (e) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

(i) Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 32. K.S.A. 2006 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of group and individual certificates of coverage and contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) The locations of all facilities, the hours of operation and the services which are provided in each facility in the case of individual practice associations or medical staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services;

(7) in the case of a health maintenance organization, a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of ~~six~~ *18* months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group

coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured 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. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (17) and (19) of subsection (j) of K.S.A. 40-2209, and amendments thereto;

(8) (A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract, whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of termination;

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A); and

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services.

(b) No health maintenance organization or medicare provider organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such provider in the event of nonpayment by the health maintenance organization or medicare provider organization for any services which have been performed under contracts between

such enrollees and the health maintenance organization or medicare provider organization. Further, any contract between a health maintenance organization or medicare provider organization and a provider shall provide that if the health maintenance organization or medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or medicare provider organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. If there is no written contract between the health maintenance organization or medicare provider organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. Any action by a provider to collect or attempt to collect from a subscriber or enrollee any sum owed by the health maintenance organization to a provider shall be deemed to be an unconscionable act within the meaning of K.S.A. 50-627 and amendments thereto.

(c) No group or individual certificate of coverage or contract form or amendment to an approved certificate of coverage or contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's or medicare provider organization's method for resolving enrollee grievances.

(e) The provisions of subsections (A), (B), (C), (D) and (E) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

(f) In lieu of any of the requirements of subsection (a), the commissioner may accept certificates of coverage issued by a medicare provider organization in conformity with requirements imposed by any appropriate federal regulatory agency.

Sec. 33. K.S.A. 2006 Supp. 75-6501 is hereby amended to read as follows: 75-6501. (a) Within the limits of appropriations made or available therefor and subject to the provisions of appropriation acts relating thereto, the Kansas state employees health care commission shall develop and provide for the implementation and administration of a state health care benefits program.

(b) The state health care benefits program may provide benefits for persons qualified to participate in the program for hospitalization, medical

services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

(c) The Kansas state employees health care commission shall designate by rules and regulations those persons who are qualified to participate in the state health care benefits program, including active and retired public officers and employees and their dependents as defined by rules and regulations of the commission. Such rules and regulations shall not apply to students attending a state educational institution as defined in K.S.A. 76-711, and amendments thereto, who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto. In designating persons qualified to participate in the state health care benefits program, the commission may establish such conditions, restrictions, limitations and exclusions as the commission deems reasonable. Such conditions, restrictions, limitations and exclusions shall include the conditions contained in subsection (d) of K.S.A. 75-6506, and amendments thereto. Each person who was formerly elected or appointed and qualified to an elective state office and who was covered immediately preceding the date such person ceased to hold such office by the provisions of group health insurance or a health maintenance organization plan under the law in effect prior to August 1, 1984, or the state health care benefits program in effect after that date, shall continue to be qualified to participate in the state health care benefits program and shall pay the cost of participation in the program as established and in accordance with the procedures prescribed by the commission if such person chooses to participate therein.

(d) As an alternative to any other coverage provided under the state health care benefits program, the commission shall provide and offer:

(1) To any qualified person a health care benefits program which provides coverage similar to the federal medicaid basic coverage plan; or

(2) to any qualified person who declines to participate in the state health care benefits program and can provide evidence of coverage under another health insurance plan, the following payments:

(A) for individual coverage	*$1,250*
(B) for family coverage	*$1,250 for each covered adult and $ 800 for each covered child*

~~(d)~~ *(e)* The commission shall have no authority to assess charges for employer contributions under the student health care benefits component of the state health care benefits program for persons who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto.

~~(e)~~ *(f)* Nothing in this act shall be construed to permit the Kansas state employees health care commission to discontinue the student health care benefits component of the state health care benefits program until the state board of regents has contracts in effect that provide student coverage pursuant to the authority granted therefor in K.S.A. 75-4101, and amendments thereto.

Sec. 34. K.S.A. 2006 Supp. 75-7408 is hereby amended to read as follows: 75-7408. (a) On and after July 1, 2006, the Kansas health policy authority shall coordinate health care planning, administration, and purchasing and analysis of health data for the state of Kansas with respect to the following health programs administered by the state of Kansas:

(1) Developing, implementing, and administering programs that provide medical assistance, health insurance programs, or waivers granted thereunder for persons who are needy, uninsured, or both, and that are financed by federal funds or state funds, or both, including the following:

(A) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto;

(B) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C.§ 1397aa et seq., and amendments thereto;

(C) any program of medical assistance for needy persons financed by state funds only, to the extent appropriations are made for such a program;

(D) the working healthy portion of the ticket to work program under the federal work incentive improvement act and the medicaid infrastructure grants received for the working healthy portion of the ticket to work program; ~~and~~

(E) the medicaid management information system (MMIS); and

(F) a phased-in premium assistance plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan under a program authorized under paragraph (1). In program years one and two, subject to other eligibility requirements, eligible participants will consist of families at and under 50% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible par-

ticipants in program year three will consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four will consist of families at an under 100% of the federal poverty level. The Kansas health policy authority is authorized to seek any approval from the centers for medicare and medicaid services necessary to accomplish the development or expansion of premium assistance programs;

(2) the restrictive drug formulary, the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided in K.S.A. 39-7,116 through 39-7,121 and K.S.A. 2006 Supp. 39-7,121a through 39-7,121e, and amendments thereto; and

(3) administering any other health programs delegated to the Kansas health policy authority by the governor or by a contract with another state agency.

(b) Except to the extent required by its single state agency role as designated in K.S.A. 2006 Supp. 75-7409, and amendments thereto, or as otherwise provided pursuant to this act the Kansas health policy authority shall not be responsible for health care planning, administration, purchasing and data with respect to the following:

(1) The mental health reform act, K.S.A. 39-1601 et seq., and amendments thereto;

(2) the developmental disabilities reform act, K.S.A. 39-1801 et seq., and amendments thereto;

(3) the mental health program of the state of Kansas as prescribed under K.S.A. 75-3304a, and amendments thereto;

(4) the addiction and prevention services prescribed under K.S.A. 65-4001 et seq., and amendments thereto; or

(5) any institution, as defined in K.S.A. 76-12a01, and amendments thereto.

Sec. 35. K.S.A. 39-785 and 40-2215 and K.S.A. 2006 Supp. 39-709, 39-709d, 40-19c06, 40-2209, 40-3209, 75-6501 and 75-7408 are hereby repealed.

Sec. 36. This act shall take effect and be in force from and after its publication in the Kansas register.