Approved April 2, 1991
Date

MINUTES OF THE House COMMITTEE ON Insurance.

The meeting was called to order by Representative Turnquist at
Chairperson

3:30 ~~a.m.~~/p.m. on Monday, April 1, 1991 in room 531 N of the Capitol.

All members were present except:

Representative Helgerson - Exempt

Committee staff present:

Bills Edds, Revisor
Chris Courtwright, Research
Gena Lott, Intern
Nikki Feuerborn, Committee Secreta

Conferees appearing before the committee:

Laird Bowman, University of Kansas Endowment Association
Eric Wade, City of Merriam
Neale Peterson, City of Fairway

Others Attending: See Attached List

Hearing on SB 115 - **Insurable interests and assignments to charitable, benevolent, educational and religious institutions**

Chris Courtwright of Research gave an explanation and history of SB 115.

Laird Bowman, Kansas Endowment Association, appeared before the committee as a proponent of the bill. In a recent court case in New York, the Internal Revenue Service would not allow an individual to deduct the value of the gift given to the charitable institution as the institution had no insurable interest in the individual. According to recent research, Kansas is one of the few states that does not allow a charitable institution to purchase life insurance on a person it does not have an insurable interest in.

Dick Brock of the Insurance Department said they have been unable to develop a definitive position on the subject because of the differing opinions in the case law. This bill will hopefully clarify the issue. (See Attachment 1).

There were no opponents to the bill.

Representative Neufeld moved for the favorable passage of SB 115 to the Consent Calendar. Representative Flower seconded the motion. Motion carried.

Hearing on SB 251 - Allow 14 municipalities in Douglas, Johnson, Leavenworth, Miami, and Wyandotte counties to enter into agreements with municipalities located in Missouri for pooling sickness and accident related liabilities.

Chris Courtwright of Research gave a review and explanation of the bill.

Eric Wade, City Administrator of Merriam, appeared before the committee as a proponent of SB 251. (See Attachment 2). This legislation would allow an existing, well run, municipal health insurance trust to continue to operate across the Kansas/Missouri state line. The pool was established in 1983 and a total of 50 small to medium sized municipalities in Missouri and Kansas participate. The insurance provides comprehensive medical and dental care at an affordable price o its members. The original bill (SB 587) allowed intrastate pools and did not mention interstate pools. The proposed amendment does three things:

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 531 N, Statehouse, at 3:30 XXX/p.m. on Monday, April 1, 1991

1. Specifically allows for municipalities to enter into agreements for the purpose of multi-state pooling for health insurance in 5 counties in accordance with the Kansas statutes regulating municipal health insurance pools.

2. Request that any investments held by the pool, including out of state funds, be invested in Kansas financial institutions and restricts the manner in which these funds are invested.

3. A per annum one percent fee applies only to Kansas members of the pool. Determines criteria for selecting trustees of the pool.

Neale Peterson, Mayor of the City of Fairway, appeared before the committee as a proponent of the bill. He testified to the success of the pool in his area and requested they be allowed to continue with MARCIT. (See Attachment 3).

Gary H. Hanson, Kansas Rural Water Association, presented written testimony in support of SB 251. (See Attachment 4).

There were no opponents appearing. The Hearing was declared closed.

The substitute bill for HB 2511 was reviewed by Bill Edds. This bill excludes all mandates and would limit provider insurance to medical doctors, osteopathic doctors, and physician assistants. The fiscal impact on the state would depend on the Economic Development Initiatives Fund. There could be assessments made at some point. If any person is eligible for participation in self-insurance plans they are exempt from participating in this proposed plan. (Attachment 5).

Representative Campbell moved we adopt the substitute bill for HB 2511 and pass is favorably from committee. Representative Weiland seconded the motion. Motion carried.

The meeting adjourned at 5:10 p.m.

GUEST LIST

COMMITTEE: House Ins. DATE: 4/1/91

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Dick Brock	Topeka	Ins Dept
LAIRD BOWMAN	LAWRENCE	KU ENDOWMENT ASSN
Chris Stanfield	TOPEKA	SRS
MIKE MORRIS	TOPEKA	CORPORATE PLAN MGMT
Gary Hanson	Topeka	KRWA
Eric Wade	Merriam	City of Merriam
Neale R. Peterson	Fairway, Ks	Mid America Regional Council
Doug Irmen	Fairway	Council Ins Trust Mid America Regional
Susan Prater	Kansas City, MO	Council Ins Trust MID AMERICA REGIONAL
Ted Frey	Merriam, Ks	City of Merriam, Ks
Anne Smith	Topeka	Ks. Assoc. of Counties
Bill Curtis	Topeka	Ks. Assoc. of School Bds.
[illegible]	Topeka	KNS
LARRY MAGILL	"	IIAK

Testimony By

Dick Brock, Kansas Insurance Department

Before the House Insurance Committee

on Senate Bill No. 115

March 27, 1991

Currently, neither Kansas statutes or case law clearly distinguish among three separate and distinct policy rights as they pertain to life insurance, i.e., (1) the right to designate a beneficiary, (2) the right of policy assignment, and (3) the right to purchase insurance on the life of another. The issue is further complicated because Kansas courts have been inconsistent with regard to their conclusion.

Consequently, the Insurance Department has been unable to develop a definitive position on the subject, again because of the differing opinions in the case law. It does seem rather clear and the Department has held that it is permissible for a charitable organization having no insurable interest in the life of the insured to be designated beneficiary of a policy; and, it is probably not permissible for a charitable organization to purchase insurance on the life of an insured with respect to whom the charitable organization has no insurable interest. However, we have been unable to form any opinion as to whether or not it is permissible for an insured to assign a policy to a charitable organization which has no insurable interest in his or her life.

Senate Bill No. 115 will hopefully clarify this issue by statutorily declaring the legal propriety of all three of the situations involved. That is, the bill will specifically provide that any person may be named as a beneficiary and that any charitable, benevolent, educational and religious institutions qualified under 501(c) of the Internal Revenue Code shall be deemed to have an insurable interest in the life of an individual for purposes of assignment of the policy or even purchase of a

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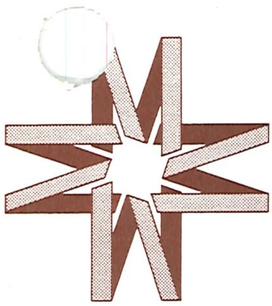
policy on the life of another. In all such cases, consent of the donating person is required.

While the introduction of Senate Bill No. 115 was initiated by the Kansas University Endowment Association, the Insurance Department supports its provisions and hope you will give it your favorable consideration.



THE CITY OF MERRIAM

9000 WEST 62nd TERRACE
MERRIAM, KANSAS 66202

(913) 722-3330

ERIC WADE
City Administrator

The following is a copy of a presentation to the Kansas House Insurance Committee on April 1, 1991 by Eric Wade, City Administrator, Merriam, in support of SB-251.

Introduction:

Good Afternoon.

It is both an honor and a privilege to have this opportunity to address this committee in support of SB-251.

By way of introduction my name is Eric Wade. I am the City Administrator in Merriam and also an executive board member of the Mid America Regional Council Insurance Trust (MARCIT).

The proposed special legislation that this committee is now considering, in very simple terms does one thing — it allows an existing, well run, municipal health insurance trust to continue to operate across the Kansas/Missouri state line.

In the next few minutes, I would like to share with you why I believe this is an important piece of legislation.

Background on MARCIT:

First, I'd like to tell you about the municipal insurance pool that this legislation, if passed, will help.

The old adage that "there is strength in numbers" is no where truer than in the business of insurance. Over the last decade, across the country, smaller municipalities have joined together in self-funding pools in an effort to help make insurance affordable. Health insurance, in particular, we have all discovered is becoming unaffordable or unavailable.

In response to this growing need, MARCIT was established in 1983 using sound underwriting and risk management techniques. Since 1984 13 municipalities in Kansas have joined this health pool . On the Missouri side MARCIT now has 37 members. A total of 50 small to medium sized municipal entities in the greater metropolitan Kansas City area now participate.

A breakdown of the employees covered under this plan shows a total of over 2,900 lives and nearly $7 million in premiums. Roughly 15% of the members and premiums are Kansas. This health insurance pool provides comprehensive medical and dental care at an affordable price to its members.

Why this legislation is necessary:

Second, I'd like to describe where our problem lies.

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April 1, 1991

As I understand, up until last year, there was no specific statute that prescribed the way a municipal health pool was to be operated. Then, when SB 587 was passed, the regulations specifically authorized the establishment of municipal health pools in the

Attachment 2

state. The language, however, authorized only intrastate pools and was silent about interstate pools. (Kansas municipalities joined MARCIT under the assumption that statutes allowing interlocal agreements and self-funding of insurance permitted their membership.)

The Kansas Insurance Department has informed the MARCIT board that the intention of the statute was to only allow intra-state pooling. Since MARCIT was informed of this last fall, we have been working cooperatively with the Insurance Department to figure out a way to continue operating. There is realistically only one option, to shut down the operation of the MARCIT in Kansas. This is causing many problems, which we are now in the process of trying to overcome.

One obvious possibility and one that we will have to pursue if this legislation doesn't pass, will be for the Kansas members to form a separate pool. This is not necessarily a good option. It would require a lot of work, time and money and result in a pool that is not as sound from an actuarial and financial standpoint because it would be considerably smaller. With the current Kansas members, the minimum premium as described in the statutes of 1 million dollars would barely be met. Operating that close to the margin is not a comforting prospect. Additionally, to start a new pool there would be all those expenses up front to get off the ground. Needless to say, there would be many transition problems.

What this bill would do:

The other and better solution to our problem is the passage of this legislation.

This bill allows an existing interstate, regional municipal health insurance pool to continue operation. The proposed amendment specifically does three things:

1. Adds a new section (12-2630) that specifically allows for municipalities to enter into agreements for the purpose of multi-state pooling for health insurance in the counties of Douglas, Johnson, Leavenworth, Miami, and Wyandotte in accordance with the Kansas statutes regulating municipal health insurance pools.

2. Requires that any investments held by the pool, including out of state funds, be invested according to KSA 12-2622 which requires the funds be invested in a Kansas financial institution. and restricts the manner in which these funds are invested.

3. Amends Sections 12-2624 so that the per annum one percent fee applies only to Kansas members of the pool and amends Section 12-2627 which amends the way that trustees are selected for such pool, giving in this instance of a multi-state pool, proportional representation based on the percent of premiums paid by Kansas entities, and also in this instance, Missouri entities.

Summary:

The following Kansas municipalities are currently members of MARCIT: Baldwin City, Basehor, Bonner Springs, Edgerton, Edwardsville, Fairway, Lansing, Leavenworth, Leawood, Mission, Merriam, Osawatomie, and Spring Hill. The financial impact on these cities if this special legislation is not passed is considerable. Some members have indicated that prior to joining MARCIT they were unable to find insurance companies that would quote them because of their small size or experience. Allowing MARCIT to continue through this legislation makes sense because it allows these cities a way to provide a benefit to their employees that is considered a traditional part of the compensation program of public employees at a savings to our collective taxpayers. Thank you.

Kansas Counties and County Seats

CHEYENNE St. Francis
RAWLINS Atwood
DECATUR Oberlin
NORTON Norton
PHILLIPS Phillipsburg
SMITH Smith Center
JEWELL Mankato
REPUBLIC Belleville
WASHINGTON Washington
MARSHALL Marysville
NEMAHA Seneca
BROWN Hiawatha
DONIPHAN Troy
SHERMAN Goodland
THOMAS Colby
SHERIDAN Hoxie
GRAHAM Hill City
ROOKS Stockton
OSBORNE Osborne
MITCHELL Beloit
CLOUD Concordia
CLAY Clay Center
RILEY Manhattan
POTTAWATOMIE Westmoreland
JACKSON Holton
ATCHISON Atchison
JEFFERSON Oskaloosa
LEAVENWORTH Leavenworth
WYANDOTTE Kansas City
WALLACE Sharon Springs
LOGAN Oakley
GOVE Gove
TREGO WaKeeney
ELLIS Hays
RUSSELL Russell
LINCOLN Lincoln
OTTAWA Minneapolis
DICKINSON Abilene
GEARY Junction City
WABAUNSEE Alma
SHAWNEE Topeka
DOUGLAS Lawrence
JOHNSON Olathe
ELLSWORTH Ellsworth
SALINE Salina
MORRIS Council Grove
OSAGE Lyndon
FRANKLIN Ottawa
MIAMI Paola
GREELEY Tribune
WICHITA Leoti
SCOTT Scott City
LANE Dighton
NESS Ness City
RUSH LaCrosse
BARTON Great Bend
RICE Lyons
McPHERSON McPherson
MARION Marion
CHASE Cottonwood Falls
LYON Emporia
COFFEY Burlington
ANDERSON Garnett
LINN Mound City
HAMILTON Syracuse
KEARNY Lakin
FINNEY Garden City
HODGEMAN Jetmore
PAWNEE Larned
STAFFORD St. John
RENO Hutchinson
HARVEY Newton
BUTLER El Dorado
GREENWOOD Eureka
WOODSON Yates Center
ALLEN Iola
BOURBON Ft. Scott
GRAY Cimmaron
FORD Dodge City
EDWARDS Kinsley
SEDGWICK Wichita
STANTON Johnson City
GRANT Ulysses
HASKELL Sublette
KIOWA Greensburg
PRATT Pratt
KINGMAN Kingman
ELK Howard
WILSON Fredonia
NEOSHO Erie
CRAWFORD Girard
MORTON Elkhart
STEVENS Hugoton
SEWARD Liberal
MEADE Meade
CLARK Ashland
COMANCHE Coldwater
BARBER Medicine Lodge
HARPER Anthony
SUMNER Wellington
COWLEY Winfield
CHAUTAUQUA Sedan
MONTGOMERY Independence
LABETTE Oswego
CHEROKEE Columbus

Please note:
City of Lawrence
is not a member

Kansas Members

Baldwin City
Basehor
Bonner Springs
Edgerton
Edwardsville
Fairway
Gardner
Lansing
Leavenworth
Leawood
Mission
Merriam
Osawatomie
Spring Hill

SB 051

BROADWAY 300 RIVERGATE CENTER
KANSAS CITY, MISSOURI 64105-1554

816 / 474-4240

MARC

MID-AMERICA REGIONAL COUNCIL

STATEMENT TO STATE HOUSE COMMITTEE

ON INSURANCE

April 1, 1991

(READING TIME --- 2 minutes)

Mr. Chairman, members of the Committee....

....I'm Neale Peterson, Mayor of Fairway in Johnson County. We've never caused enough trouble for anyone to make ourselves known. So let me tell you that we are a small city of a few more than 4, 000 souls. And, we are located at little bit across the State Line from the Plaza in Kansas City, Missouri.

As for me -- short of an assassination attempt, or a recall effort, upon returning home today -- I will have survived the Mayor's role for about 30 years. During most of that time -- up UNTIL 1984 with the advent of MARCIT -- we struggled with the problem of providing health insurance for our 15 full-time employees. And, to do so, with careful concern for its cost to our taxpayers. An example of just what MARCIT can do, and did do for us 6 years ago, our long-serving Police Chief underwent the first liver transplant ever done at the Nebraska University Medical Center in Omaha, where KU Med sent him by helicopter at the very last minute. Today, he is retired and in good health. MARCIT covered that procedure and its ongoing costs, which very probably would not have been done by a commercial carrier.

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Chairman
Johnna Lingle
Commissioner
Johnson County, KS

1st Vice Chairman
John O'Renick
Mayor
Sugar Creek, MO

2nd Vice Chairman
Neale Peterson
Mayor
Fairway, KS

Secretary
Frank Corbett
Councilman
Kansas City, KS

Treasurer
Betty Gregoire
County Assessor
Platte County, MO

David A. Warm
Executive Director

PRINTED ON RECYCLED PAPER

That's enough about Fairway's good experiences with MARCIT, because I also appear here today as Board Vice Chairman of the Mid America Regional Council, which conceived and gave birth to this Trust and with whom we share our MARC acronyumn.

MARC is the central planning agency for the Metropolitan Kansas City region serving over 1.5 million people residing in both Kansas and Missouri with representation from 8 counties and 112 cities. MARC has been the guiding factor in focusing on resolution of our common bi-state needs. Our particularly visible successes include development and implementation of the Metro 9-1-1 system and the beginning of flood control across the State Line.

In conclusion, please know that MARCIT has proven to be another of our most notable successes. And, we fervently hope not to loose it and know that with your support -- we won't. In your deliberations, I suggest each of you remember that all of us in public office have a fiduciary responsibility, as well as a moral obligation, to habor our constituants' tax dollars. The Trust has permitted its members to do just that by holding down costs through pooling our risks without impedance of the State Line and by being kept immune from the vagaries of a profit-oriented market place.

Thank you for your attention and consideration.

LAW OFFICES

STUMBO, HANSON & HENDRICKS

2887 S.W. MacVICAR AVENUE

TOPEKA, KANSAS 66611

TELEPHONE (913) 267-3410

FAX (913) 267-9516

GARY H. HANSON
LARRY D. HENDRICKS

TOM R. BARNES II

OF COUNSEL:
WALTER G. STUMBO
JOHN E. STUMBO

DATE: April 1, 1991

TO: House Committee on Insurance

FROM: Gary H. Hanson, Kansas Rural Water Association

TESTIMONY OF GARY H. HANSON IN SUPPORTING
AMENDED SENATE BILL No. 251

The Kansas Rural Water Association (KRWA) is an association of water utilities including Rural Water Districts and cities.

KRWA supports the concept of insurance pools as a means for Kansas municipalities to control their insurance costs. KRWA has sponsored such a plan called the Rural Water Systems Insurance Trust since 1983. After passage of amendments to the Kansas Municipal Group Funded Pool Act in 1990, KRWA has been actively attempting to form a pool of KRWA member municipalities and water districts to comply with that Act.

KRWA supports the bill as amended because, although it creates an exception to certain existing requirements for certain counties, it requires that Kansas law apply unless the pool's state laws are more stringent. While this may present some interpretive and enforcement problems for the Insurance Commissioner, the result appears to provide equivalent treatment for all group funded pools in Kansas.

Respectfully submitted,

GARY H. HANSON

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SUBSTITUTE FOR HOUSE BILL NO. 2511

By Committee on Insurance

AN ACT providing for the creation and operation of the Kansas uninsurable health insurance plan; amending K.S.A. 79-4804 and repealing the existing section.

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

New Section 1. This act shall be known and may be cited as the Kansas uninsurable health insurance plan act.

New Sec. 2. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

(a) "Administering carrier" means the insurer or third-party administrator designated in section 4 of this act.

(b) "Association" means the Kansas health insurance association established in section 3 of this act.

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

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

(e) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include insurance arising out of the workers compensation act 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

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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 in this state.

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

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

(k) "Member" means all insurers and insurance arrangements participating in the association.

(l) "Plan" means the Kansas uninsurable health insurance plan created pursuant to this act.

(m) "Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, bylaws and operating rules, adopted by the board pursuant to section 3 of this act.

New Sec. 3. (a) There is hereby created a nonprofit legal entity to be known as the Kansas health insurance association. All insurers and insurance arrangements providing health care benefits in this state shall be members of the association. The association 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 association shall be selected by members of the association subject to the approval of the commissioner. To select the initial board of directors, and to initially organize the association, 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 plan for expenses incurred by them as members of the board of directors but shall not otherwise be compensated by the plan for their services.

(2) The board shall submit to the commissioner a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. 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 plan and provides for the sharing of association losses on an equitable proportionate basis among the members of the association. 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. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

(A) Establish procedures for the handling and accounting of assets and moneys of the plan;

(B) select an administering carrier in accordance with section 4 of this act;

(C) establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to section 5 of this act. Assessments shall be due and payable within 30 days of receipt of the assessment notice;

(D) establish appropriate cost control measures, including but not limited to, preadmission review, case management, utilization review and exclusions and limitations with respect to treatment and services under the plan; and

(E) develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(c) The association 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). The association shall have the general powers and authority granted under the laws of this state to insurers licensed to transact the kind of health service or insurance included under section 7 of this act, 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;

(3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage

provided by or through the plan;

(4) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. During the first two years of operation of the plan, rates shall be established in an amount that is estimated by the board to cover all claims that may be made against the plan and the expenses of operating the plan. In following years, rates for coverage shall be reasonable in terms of the benefits provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex and geographic location in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(5) assess members of the association in accordance with the provisions of section 5 of this act;

(6) issue policies of insurance in accordance with the requirements of this act; and

(7) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

New Sec. 4. (a) The board shall select an insurer or third-party administrator to administer the plan. 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) the efficiency of the bidder's claim paying procedure;

(3) an estimate of total charges for administering the plan; and

(4) the bidder's ability to administer the plan 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, eligibility and administrative claims payment functions relating to the plan, including:

(1) Establishing a billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;

(2) performing all necessary functions to assure timely payment of benefits to covered persons under the plan including making available information relating to the proper manner of submitting a claim for benefits to the plan, distributing forms upon which submission shall be made and evaluating the eligibility of each claim for payment under the plan;

(3) accepting payments of premiums from insured persons and transmitting such payments to the state treasurer for credit to the uninsurable health insurance plan fund established in section 10 of this act;

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

(5) determining net written and earned premiums, the expense of administration, and the paid and incurred losses for each year and reporting such information to the board and the commissioner in a form and manner prescribed by the commissioner.

New Sec. 5. (a) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the plan

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

(b) In addition to any assessment authorized by subsection (a) of this section, the board may assess the members of the association for any initial costs associated with developing and implementing the plan to the extent such costs exceed the funds transferred to the uninsurable health insurance plan fund pursuant to subsection (h) of K.S.A. 79-4804, and amendments thereto. Such assessment shall be allocated among the members of the association in the manner prescribed by subsection (a) of this section or any other equitable formula established by the board. Assessments under this subsection shall not be subject to the credit against premium tax under subsection (c) of this section.

(c) Except as hereinafter provided, 80% of any assessment

made against a member of the association pursuant to subsection (a) of this section may be claimed by such member as a credit against such member's premium or privilege tax liability imposed by K.S.A. 40-252 or 40-3213 or K.S.A. 1990 Supp. 12-2624, and amendments thereto, for the taxable year in which such assessment is paid. No credit shall be allowed with respect to any assessment made for net losses incurred during the first two years of operation of the plan.

Sec. 6. (a) Except for those persons who meet the criteria set forth in subsection (b) of this section, any person who has been a resident of this state for at least six months prior to making application for coverage shall be eligible for plan coverage if such person is able to provide evidence satisfactory to the administering carrier that such person meets one of the following criteria:

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

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

(3) such person has applied for health insurance and has been quoted a premium rate which:

(A) In the first two years of operation of the plan, is more than 150% of the premium rate available through the plan; or

(B) in succeeding years of operation of the plan, is in excess of the premium rate established for plan coverage in an amount set by the board; or

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

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

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

(2) any person who has had coverage under the plan

terminated less than 12 months prior to the date of the current application;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by section 8 of this act;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan; or

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

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

New Sec. 7. (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of section 8 of this act.

(b) Except for those expenses set forth in subsection (c) of this section, expenses covered under the plan shall include expenses for:

(1) Services of persons licensed to practice medicine and surgery which are medically necessary for the diagnosis or treatment of injuries, illnesses or conditions, other than mental;

(2) services of advanced registered nurse practitioners who hold a certificate of qualification from the board of nursing to practice in an expanded role or physicians assistants acting under the direction of a responsible physician when such services are provided at the direction of a person licensed to practice medicine and surgery and meet the requirements of paragraph (b)(1) above;

(3) services of licensed dentists issued certificates of qualification by the board of dental examiners to practice oral surgery as a dental specialty when such procedures would otherwise be performed by persons licensed to practice medicine

and surgery;

(4) emergency care, surgery and treatment of acute episodes of illness or disease as defined in the plan and provided in a general hospital or ambulatory surgical center as such terms are defined in K.S.A. 65-425, and amendments thereto;

(5) medically necessary diagnostic laboratory and x-ray services as limited by the plan; and

(6) drugs and controlled substances prescribed by a physician. Coverage for outpatient prescriptions shall be subject to a mandatory 50% coinsurance provision, and coverage for prescriptions administered to inpatients shall be subject to a coinsurance provision as established in the plan.

(c) Expenses not covered under the plan shall include expenses for:

(1) Illness or injury due to an act of war;

(2) services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred;

(3) services for which no charge would be made in the absence of insurance or for which the insured bears no legal obligation to pay;

(4) (A) services or charges incurred by the insured which are otherwise covered by:

(i) Medicare, medicaid or state law or programs;

(ii) medical services provided for members of the United States armed forces and their dependents or for employees of such armed forces;

(iii) military service-connected disability benefits;

(iv) other benefit or entitlement programs provided for by the laws of the United States;

(v) workers compensation or similar programs addressing injuries, diseases, or conditions incurred in the course of employment covered by such programs;

(vi) benefits payable without regard to fault pursuant to any motor vehicle or other liability insurance policy or

equivalent self-insurance.

(B) This exclusion shall not apply to services or charges which exceed the benefits payable under the applicable programs listed above and which are otherwise eligible for payment under this section.

(5) Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;

(6) that part of any charge for services or articles rendered or prescribed which exceeds the rate established by section 13 of this act for such services;

(7) services or articles not medically necessary;

(8) care which is primarily custodial or domiciliary in nature;

(9) cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(10) eye surgery if corrective lenses would alleviate the problem;

(11) experimental services or supplies not recognized by the appropriate medical board as the normal mode of treatment for the illness or injury involved;

(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and

(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

(d) The plan may contract for coverage within the scope of this act notwithstanding any mandated coverages otherwise required by state law. The provisions of K.S.A. 40-2,100 to 40-2,105, inclusive, 40-2,114, 40-2209 and K.S.A. 1990 Supp. 40-2229, 40-2230 and 40-2250, and amendments thereto, shall not be applicable with respect to any coverage provided by the plan.

New Sec. 8. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. The

plan may offer applicants for coverage thereunder a choice of deductible and copayment options or combinations thereof. At least one option shall provide for a minimum annual deductible of $5,000. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop loss provision. However, such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $500,000 per covered individual.

(c) In the first two years of operation of the plan, coverage thereunder shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage as to any condition which manifested itself during the six-month period immediately prior to the application for coverage in such manner or would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions thereunder may be excluded as determined by the board except that no such exclusion shall exceed 12 months.

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

(2) The association shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not covered expenses. Benefits due from the plan may

be reduced or refused as a set-off against any amount recoverable under this section.

Sec. 9. K.S.A. 79-4804 is hereby amended to read as follows: 79-4804. (a) An amount equal to 60% of all moneys credited to the state gaming revenues fund shall be transferred and credited to the state economic development initiatives fund which is hereby created in the state treasury. Expenditures from the state economic development initiatives fund shall be made in accordance with appropriations acts for the financing of such programs supporting and enhancing the existing economic foundation of the state and fostering growth through the expansion of current, and the establishment and attraction of new, commercial and industrial enterprises as provided by this section and as may be authorized by law and not less than 1/2 of such money shall be distributed equally among the five congressional districts. On and after July 1, 1990, an amount equal to 90% of all moneys credited to the state gaming revenues fund shall be transferred and credited to the state economic development initiatives fund created by this section. Except as provided by ~~subsection~~ subsections (g) and (h), all moneys credited to the state economic development initiatives fund shall be credited within the fund, as provided by law, to an account or accounts of the fund which are created by this section.

(b) There is hereby created the Kansas capital formation account in the state economic development initiatives fund. All moneys credited to the Kansas capital formation account shall be used to provide, encourage and implement capital development and formation in Kansas.

(c) There is hereby created the Kansas economic development research and development account in the state economic development initiatives fund. All moneys credited to the Kansas economic development research and development account shall be used to promote, encourage and implement research and development programs and activities in Kansas and technical assistance funded through state educational institutions under the supervision and

control of the state board of regents or other Kansas colleges and universities.

(d) There is hereby created the Kansas economic development endowment account in the state economic development initiatives fund. All moneys credited to the Kansas economic development endowment account shall be accumulated and invested as provided in this section to provide an ongoing source of funds which shall be used for economic development activities in Kansas, including but not limited to continuing appropriations or demand transfers for programs and projects which shall include, but are not limited to, specific community infrastructure projects in Kansas that stimulate economic growth.

(e) Except as provided in subsection (f), the pooled money investment board may invest and reinvest moneys credited to the state economic development initiatives fund in obligations of the United States of America or obligations the principal and interest of which are guaranteed by the United States of America or in interest-bearing time deposits in any commercial bank located in Kansas, or, if the board determines that it is impossible to deposit such moneys in such time deposits, in repurchase agreements of less than 30 days' duration with a Kansas bank or with a primary government securities dealer which reports to the market reports division of the federal reserve bank of New York for direct obligations of, or obligations that are insured as to principal and interest by, the United States government or any agency thereof. All moneys received as interest earned by the investment of the moneys credited to the state economic development initiatives fund shall be deposited in the state treasury and credited to the Kansas economic development endowment account of such fund.

(f) Moneys credited to the Kansas economic development endowment account of the state economic development initiatives fund may be invested in government guaranteed loans and debentures as provided by law in addition to the investments authorized by subsection (e) or in lieu of such investments. All

moneys received as interest earned by the investment under this subsection of the moneys credited to the Kansas economic development endowment account shall be deposited in the state treasury and credited to the Kansas economic development endowment account of the state economic development initiatives fund.

(g) In each fiscal year beginning on and after July 1, 1990, the director of accounts and reports shall make transfers in equal amounts on July 15 and January 15 which in the aggregate equal $2,000,000 from the state economic development initiatives fund to the state water plan fund created by K.S.A. 82a-951. No other moneys credited to the state economic development initiatives fund shall be used for: (1) Water-related projects or programs, or related technical assistance; or (2) any other projects or programs, or related technical assistance, which meet one or more of the long-range goals, objectives and considerations set forth in the state water resource planning act.

(h) On July 15, 1991, and July 15, 1992, the director of accounts and reports shall make transfers of $1,000,000 each from the state economic development initiatives fund to the uninsurable health insurance plan fund created by section 10 of this act.

New Sec. 10. There is hereby created in the state treasury a fund to be known and designated as the uninsurable health insurance plan fund. All premium payments transmitted by the administering insurer and all moneys from assessments made pursuant to section 5 of this act and deposited by the commissioner shall be credited by the state treasurer to the uninsurable health insurance plan fund. All moneys credited to the uninsurable health insurance plan fund shall be used to pay claims and expenses of the operation of the plan. All expenditures from the uninsurable health insurance 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 commissioner or a person or persons designated by the commissioner.

New Sec. 11. (a) Not later than July 1, 1992, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.

(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, 1994. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.

New Sec. 12. The association or a member insurer thereof shall provide every applicant for health coverage under the provisions of this act with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition in substantial conformance with subsection (c) of K.S.A. 65-28,103, and amendments thereto. If such applicant elects to execute such declaration the applicant shall submit a copy of such declaration to the association or member insurer thereof, and such copy shall be retained and made a part of the applicant's permanent records.

New Sec. 13. Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association under which reimbursement for services provided shall be at the rates the state reimburses such providers for services rendered under medicaid pursuant to rules and regulations of the secretary of social and rehabilitation services. Providers shall not charge persons covered under the plan with the exception of authorized deductible and co-pay requirements and noncovered services if the recipient has been informed in advance of the noncoverage.

Sec. 14. K.S.A. 79-4804 is hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the Kansas register.

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