Approved February 26, 1992
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 Wednesday, February 19, 1992 in room 531 N of the Capitol.

All members were present except:

Committee staff present:

Mr. Fred Carman, Revisor
Mrs. Emalene Correll, Research
Mr. Chris Courtwright, Research
Mrs. Nikki Feuerborn, Secretary

Conferees appearing before the committee:

Discussion and final action on HB 2511 - an act providing for the creation and operation of the Kansas uninsurable health insurance plan.

Information from podiatrists regarding their opposition to the plan was distributed. (See Attachments 1, 2, 3, and 4).

Mr. Dick Brock of the Insurance Department presented the committee with amendments in balloon form for **HB 2511.** (See Attachment 5).

Representative Neufeld moved to adopt the suggested amendment on Page 4 of the bill and instructed the revisor to make any technical corrections. Representative Sprague seconded the motion. Motion carried.

Representative Welshimer moved we conceptually amend Page 8 Line 1 by changing "physician" to "practineer." Representative Neufeld seconded the motion. Motion carried.

Representative Neufeld moved to adopt the amendment on Page 8 Line 43 and Page 9 Line 1. Representative Gilbert seconded the motion. Motion carried.

Representative Neufeld made a conceptual motion to strike all of Section 4C on Page 9 Line 8 and insert the appropriate language from SB 561. The revisor was instructed to make all technical changes including references to previous acts and existing statutes. Representative Cornfield seconded the motion. Motion carried.

Representative Welshimer moved to strike "issued certificates of qualification by the board of dental examiners" on Page 7 Lines 34 and 35. Representative Cozine seconded the motion. Motion carried.

Representative Sprague moved to have the transfer of $1 million for two years for this plan from the general fund. This money is to be paid back, interest free, within ten years. This would be subject to appropriations. The revisor would make all technical changes including adjusting start-up dates . All of Section 9 on Pages 11 and 12 would be struck. Representative Helgerson seconded the motion. Motion carried.

Representative Weiland moved to conceptually authorize the revisor to make all necessary changes in dates. Representative Neufeld seconded the motion. Motion carried.

Representative Weiland moved to strike other than mental on Page 7 Line 27, "other than mental." Representative Cozine seconded the motion. Motion carried.

Representative Weiland moved to delete "as limited by the plan" from Page 7 Line 43. Representative Sebelius seconded the motion. Motion carried.

CONTINUATION SHEET

MINUTES OF THE House COMMITTEE ON Insurance,

room 531 N, Statehouse, at 3:30 ~~a.m.~~/p.m. on Wednesday, February 19, 1992.

Representative Welshimer moved to report Substitute HB 2511 for favorable passage as amended. Representative Weiland seconded the motion. Motion carried.

Representative Helgerson moved for the adoption of the minutes of February 17, 1992. Representative Sebelius seconded the motion. Motion carried.

Meeting adjourned at 5:00 p.m.

GUEST LIST

COMMITTEE: Insurance DATE: 2-19-20

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
PAUL M KLOTZ	Topeka	ASSOC. OF CMHCs KS, Inc
Mick L. Baird, RN	Manhattan	KSHE - Hemophilia
Dick Brock	Topeka	Ins Dept
Gary Robbins	"	Ks Opt assn
David Hanzlick	"	KS. Dental Assn
Brad Smoot	"	AIA
Bob Williams	"	Ks. Pharmacists Assoc.
Kerry Townsend	Topeka	KS Hospital Assoc.
Bick Liby	Topeka	Gehrt & Roberts
Bill Sneed	TOPEKA	NFIB

JAMES E. REEVES, D.P.M., P.A.
HILLCREST PROFESSIONAL BUILDING 930 IOWA STREET SUITE 2
LAWRENCE, KANSAS 66044 (913) 841-4225

Date: 2-4-92

House Insurance Committee

RE: Substitute for House Bill No. 2511, AN ACT providing for the creation and operation of the Kansas uninsurable health insurance plan; amending KSA 79-4804 and repealing the existing section.

Dear Committee Member;

I am very interested in producing an afforable and complete health insurance program for all of Kansas and for the most part, all of America. To produce this, you have to determine what procedures will be covered under this plan. Once the types of procedures are determined, then you must look at the most affordable way to provide it. Determining your providers first, then the therapies that will be provided, you will not be providing the most coverage at the lowest cost.

We as Podiatrists provide effective care for the foot and ankle with reasonable expenses. Podiatry is very effective in controlling health care costs (Source: Aetna FEHBP 1982).

The removal of specialized professions, routinely increases health care cost. More ancillary testing, which sometimes is not necessary, is preformed and more work time is usually lost. I routinely see patients that have had multiple testing by their doctor before I see them and alot of these tests are not needed to evaluate the patients and make a diagnosis. This requires a specialist to make this diagnosis.

A large number of Podiatrist, including myself, preform a large number of office based surgeries that cut costs more than half. If Podiatry was eliminated, these surgeries would still be preformed, but would be done by Orthopedists in the hospital, which doubles the cost.

In addition, patients should still have freedom of choice. If a procedure is allowed, the patient should be free to choice the physician they want to see. This should include Podiatry.

If the insurance company that is to regulate this program,

Ins. Committee
2-19-92

Attachment 1

JAMES E. REEVES, D.P.M., P.A.
HILLCREST PROFESSIONAL BUILDING 930 IOWA STREET SUITE 2
LAWRENCE, KANSAS 66044 (913) 841-4225

Podiatry from the system. We can provide that care better than any other profession. Medicare states that Podiatrists are Physician and Surgeon of the Foot and that states that any care allowed on the foot and ankle by this bill, Podiatry should be part of it.

When considering this House bill , be careful where you draw the line in coverage. This line could result in higher health care costs and possibly reduced care.

Respectfully submitted,

James E Reeves DPM

JER/kp

K P M A
Kansas Podiatric Medical Association

615 S. Topeka Blvd. • Topeka, Kansas 66603 • (913) 354-7611

February 13, 1992

Ms. Nikki Feuerborn
Secretary for the House Insurance Committee
Room 115-S, Statehouse
Topeka, Kansas 66612

In Re: Substitute for House Bill #2511

Dear Ms. Feuerborn:

With regard to our telephone conversation today, enclosed herewith are statements by the following persons:

James E. Reeves, D.P.M., P.A.
Phyllis A. Ragley, D.P.M.
Warren W. Abbott, D.P.M.

The Kansas Podiatric Medical Association is not opposed to the bill itself as such, but do strenuously object and are very strongly opposed to that language on page 9 (13)(d) wherein they stricken from the bill the inclusion of Podiatry. The bill states on page 9, line 8 (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,...."

If the Committee desires that these persons be present to testify please advise as they are most willing to do so.

Sincerely,

Wayne Probasco

WP/jc

cc: Donald D. Yoder, D.P.M., President
James E. Reeves, D.P.M.
Phyllis A. Ragley, D.P.M.
Warren W. Abbott, D.P.M.
File

House Ins.
Attachment 2
2-1992

WARREN W. ABBOTT, D.P.M.
PODIATRIC MEDICINE
RECONSTRUCTIVE FOOT SURGERY

February 5, 1992

Committee on Insurance

IN RE: Substitute bill for House Bill 2511, An act providing for the creation and operation of Kansas Uninsurable Health Insurance Plan; amending KSA 79-4804 and repealing the existing section.

Good Afternoon.

I am Warren W. Abbott, D.P.M, a practicing podiatrist in Topeka, Kansas. I have been in practice for approximately 14 years. Ihave served on the Board of Directors for the Podiatric Medical Association for a number of years. I have also served on various committees. I have taught at the VA Podiatric Residency Program in Topeka, Kansas. I am board certified in podiatric medicine and surgery. I have lectured both nationally and internationally in the field of podiatry.

I am representing the Kansas Podiatric Medical Association. We are opposed to this bill in regards to Section 7, part D (page 9, line 10). The provisions of KSA 40-20.100 exclude podiatrists. We feel we should be included.

In the State of Kansas, a podiatrist is duly licensed by the State Board of Healing Arts as a specialist and practioner of the foot. We are licensed to treat the human foot by medical, surgical and mechanical means. We are permitted full prescription writing privileges which include prescribing narcotics.

We, as specialists of the foot, feel that we should be reimbursed for our services like anyone else in the State of Kansas when it is lawfully within the scope of our practice.

A published study at John Hopkins has indicated that over 60% of all foot surgeries are now being performed by podiatrists. For major procedures, the podiatric charges are approximately 10% less than orthopedic surgeons (source: Aetna FEHBP 1982). The study further stated that approximately 50% of these surgeries are performed in surgery centers or offices. Surgeries performed in surgery centers and offices are more cost efficient than surgeries performed in hospitals.

In fact, the charges generated by podiatrist, in hospitals, have statistically been shown to be cost effective. The ELM Services, Inc. study compared DPM's in-patient admission charges for podiatrists with those of other health care providers within comparable DRG's. Charges generated by podiatrists were considerably lower. Utilizing data of over 150,000 admissions, the analysis documented shorter lengths of stay, more economical use of drugs, radiology, laboratory and other ancillary services as major contributors to the savings. In one DRG alone, podiatrists accounted for 20% of all procedures performed. Had they performed every procedure within the DRG, it would have cost the hospital $400,000 less.

House Ins.
2-19-92
Attachment 3

2200 S.W. 6TH STREET TOPEKA, KANSAS 66606 TELEPHONE (913) 235-6900

By not including podiatrists, there is a restriction of freedom of choice by the patient. This prevents the patient from receiving the best possible foot care in the most cost effective manner.

It is noted that licensed dentists who specialize in oral surgery will be able to participate and perform certain procedures. We feel that we are a similar skilled group. Comparable to oral surgeons, but we deal with feet.

In conclusion, the Kansas Podiatric Medical Association is asking that Podiatrists be included, since we have a proven track record for being able to deliver excellent foot care in a cost effective manner. We request that we be reimbursed at the same rate as anyone else.

Respectfully submitted,

Warren W. Abbott, D.P.M.

Warren W. Abbott, D.P.M.

PHYLLIS A. RAGLEY, D.P.M.
FELLOW AMERICAN ACADEMY OF PODIATRIC SPORTS MEDICINE

February 4, 1992

House of Representatives
State of Kansas
Topeka, Kansas 66603

re: House Bill 2511

Dear Committee Members:

I am writing to you to state my reasons for opposing House Bill 2511.

Specifically, by not including podiatrists in House Bill 2511, patients' freedom of choice, as currently prescribed in K.S.A. 40-2, 100, will be eliminated. A recent Johns Hopkins University and ELM Services, a health research firm, reported 60% fo all foot surgery in the United States was performed by podiatrists, This data clearly demonstrates that when given the choice, most people select podiatrists to perform their foot operations. If House Bill 2511 passes, insureds in that bill will not have the freedom to choose the practitioner most often selected to perform foot surgery. By foreclosing podiatry from foot surgery in this bill, a virtual monopoly of foot surgery will be created. As can be appreciated, fees in a monopolistic environment may not be cost effective.

Beyond the issue of foot surgery, is the area of general foot problems. Part B Medicare Annual Data for 1986, demonstrated that podiatrists received 75% of all foot care reimbursements. Again, podiatrists were the clear choice of this group for foot care.

Besides these two groupings of patients, walkers, workers, runners and others often seek a podiatrist first for their foot care. House Bill 2511 would create a barrier to these people receiving cost-efficient, effective foot care, as well.

In conclusion, I do not support House Bill 2511 because it forcloses the fundamental right of a patient to choose which practitioner will manage their particular condition. This bill can also substantially reduce competition and create a monopoly in foot care, ultimately raising costs. The newly insured in this bill would best be served by supporting measures such as K.S.A. 40-2, 100, and not House Bill 2511.

Thank you for your time and consideration.

Sincerely,

Phyllis A. Ragley, D.P.M, J.D.

cc: Warren Abbott, D.P.M.
Wayne Probasco, J.D.

House Ins. Committee
2-19-92

330 MAINE
~~801 KENTUCKY, SUITE 104~~ LAWRENCE, KANSAS 66044 TELEPHONE (913) 843-4202

Attachment 4

(Reprint)

Session of 1991

Substitute for HOUSE BILL No. 2511

By Committee on Insurance

4-2

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 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

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2-19-92
Shawnee.

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, rea-

Page 2 of 5

sonable 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

Page 345

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.

(6) design the policy of insurance to be offered by the plan which covers only the expenses enumerated in section 7(b) of this act but with such limitations and optional benefit levels as the plan may prescribe;

(7)

(8)

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

Page 4 of 5

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

Page 5 of 5

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

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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;~~ Delete

(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 Delete

Page 795

(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 ap-~~ generally

Delete

(7) the costs of treatment for alcoholism, drug abuse and nervous or mental conditions, limited to 100% of the first $100, 80% of the next $100 and 50% of the next $1,640 in any one year and $7,500 in the covered person's lifetime. For the purpose of this paragraph, the term "nervous or mental conditions" shall have the meaning ascribed by K.S.A. 40-1,205(b) and amendments thereto.

Page 8 of 5

~~propriate 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

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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 ½ 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, objec-

tives 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

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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.

Apr. 13, 85