Approved: March 6, 1997
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Don Steffes at 9:00 a.m. on February 25, 1997 in Room 529-S of the Capitol.

All members were present except:

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Kathleen Sebelius, Insurance Commissioner
Tom Wilder, Insurance Department
William Sneed, Health Insurance Associations of America

Others attending: See attached list

Hearing on SB 204 - Group and individual policies of insurance (Kassebaum/Kennedy bill)
Insurance Commissioner Sebelius walked the Committee through the bill which is considered the "most sweeping" federal health care plan every passed (Attachment 1). She reviewed the areas affected and the agencies involved in writing the legislation. If a state does not comply with the minimum standards set by the federal government by July 1, 1997, the federal government will take over regulation of the insurance market of that state and make sure the law is followed. All of the federal rules have not been written by the three agencies involved so it has been difficult for the states to write legislation as mandated by the federal government. The real focus in Kansas is: What is the definition of small group? and How to implement "individual portability." Kansas has opted to define a small group as 2-50 even though the Commissioner recommends a small group could be defined as one. The portability issue affects only a small group who have changed jobs and moved from one group policy to an individual policy, had insurance for the past 18 months, and used their 18 months of COBRA coverage. They would have access without any "pre-existing" exclusions being applied. The current debate is between placing these 1000 to 1500 Kansans in the high risk pool or under the plan indicated in **SB 204**. The ultimate goals is be able to offer more affordable and available health plans for individuals. The Commissioner recommended **SB 204** be placed in an interim study.

Tom Wilder, Kansas Insurance Department, reviewed the bill and their proposed amendments (Attachment 2).

Senator Praeger presented the Committee with the fiscal note on the bill (Attachment 3). She also presented an amendment to be inserted on Page 28, and entitled subparagraph 3 after (h) regarding group policy enrolles (Attachment 4).

William Sneed, representing Health Insurance Agencies of America, testified as an opponent to the Commissioner's attempt to conform to the Kassebaum/Kennedy bill (Attachment 5). He presented an amendment which would implement the high risk pool as an alternative mechanism and eliminate adoption of the federal default rules, and other technical changes clarifying pre-existing and waiting periods.

Senator Praeger said that at this time it is unknown what the impact will be on the individual market nor when individual portability kicks in. She also suggested an interim comprehensive study regarding the individual market.

Chairman Steffes closed the hearing.

Senator Praeger moved to adopt the balloon amendments as presented by the Insurance Department and her amendment for Page 28. The motion was seconded by Senator Feleciano. Motion carried.

Senator Praeger moved to pass the bill out favorably as amended. Motion was seconded by Senator Feleciano. Motion carried.

The meeting was adjourned at 10:02 a.m. The next meeting is scheduled for March 5, 1997.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/25/97

NAME	REPRESENTING
Brad Smoot	BCBS
Rich Hemsley	Ks. Ins. Dept
Pat Morris	K.A.I.A.
Rich Guthrie	Health Midwest
Doug Wareham	SRS-Medical Services
Bill Sneed	HIAA
John Federici	Pate McGill & Assoc
Meg Henson	KMCS
Mary Ellen Conlee	via Christi Health System
Danielle Noe	Governor's Office
Kevin Davis	Am. Family
Bob Harder	MPS
Callie Jill Denton	K. Peterson & Assoc
Theresa Stenaumer	State Farm
STEVE KEARNEY	CIGNA
David Hanson	Ks Insur Assocs
Michael Gramlich	Corporate Communications Group (HIAA)
Brenda DeCoursey	KS. Insurance Dept.
Brian Hunt	American Cancer Society

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: _____

NAME	REPRESENTING
Tom Wilder	Kansas Insurance Dept

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

To:Senate Financial Institutions and Insurance Committee
From: Kathleen Sebelius
Re: SB 204 on Kassebaum / Kennedy

OVERVIEW:

This is the most sweeping federal health care bill ever passed. It amends the health laws, amends ERISA for the first time since it was passed in 1974 so that self-funded plans must comply with these rules, and amends all sorts of other statutes. Three federal agencies: HHS for the health rules, Department of Labor for the ERISA rules and the Treasury Department, for the tax laws, will be involved in writing regulations for implementation.

The federal law affects seven areas: group insurance, individual insurance, tax benefits for long term care insurance, tax benefits for medical savings accounts, tax benefits for viatical settlements, some medicare supplemental insurance changes, administrative simplification (whatever that means!), mental health parity, and 48 hour hospital stays.

The law is written to establish minimum standards which states must meet by July 1, 1997. The "big stick" is that if states are not in compliance, the feds will take over regulation of the insurance market, and make sure that the new law is followed. (Therefore doing nothing this session is not a viable option).

The mandate is further complicated by the fact that federal rules and regs are being written by three federal agencies, and won't be in place for a long while, so states are left to "shoot in the dark".

KANSAS SITUATION:

SB 204 is primarily aimed at group and individual health insurance changes. Much of the bill focuses on timetables and definitions which need to change in the Kansas statute to be in compliance with the feds. It is clear to all that we need to make these changes.

The real focus of the discussion in the legislature is over two policy issues where states do have a choice about how to comply with federal rules. They are: what the definition should be of a "small group" in Kansas, and how to implement "individual portability".

Senate FI & I
Attachment 1
2/25/97

420 SW 9th Street
Topeka, Kansas 66612-1678
ksebelius@ins.wpo.state.ks.us

913 296-3071
Fax 913 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

1. small group
Kansas, like 40 other states, has passed small group reform laws which already exceeds most of the standards in Kassebaum / Kennedy. We will have to change the size of small groups in our law. Current statute says that a "small group" for insurance purposes is 3 - 50 persons. Federal law says that states MUST define a small group as 2 - 50, but CAN define it as 1- 50.

In SB 204 I have recommended that Kansas lower our group size to groups of one. It would give self -employed Kansans the opportunity to buy group insurance products and deduct the entire amount from income taxes, like employers who purchase group coverage for employees can deduct the entire amount of their contributions.

Kansas is one of the states more likely to have a larger percentage of our nonelderly population insured in the individual market because we have more farmers, more self-employed, and more workers in small firms whose owners don't provide health insurance, according to a 11/96 GAO study.

Under the new federal definition, if an employer has a second employee who works at least 30 hours a week, he or she could buy group insurance for themselves and the employee. If that same Kansan is self-employed, or does not have an additional worker, he or she is out of luck in the group market. There are protections in both the federal law and the Kansas law for group insurance, that don't exist in the individual market. Group insurance policies have to be renewed each year, and there are some rate restrictions in Kansas law. Our law also prohibits medical underwriting of group insurance. I think that self employed Kansans should have access to these products as an alternative to the individual market.

The insurance companies have opposed this change. They say that rates will increase and people will "cheat" the system, but in Colorado, where this law exists, that has not been the case.

2. individual portability:
Kassebaum / Kennedy is designed to keep those who are already in the insurance market from being dumped out if they change jobs and have to move from group to individual coverage. The bill only applies to A LIMITED NUMBER of individuals; only those people who have had insurance for the past 18 months, and then use their 18 months of COBRA coverage get these new benefits.

The bill says that for these "federally qualified" citizens, they must have access to individual insurance coverage without any pre-existing condition exclusions being applied. (our current law has no protections in individual insurance, so those Kansans with a health condition, or whose children have a health condition, are scared to leave a job with group insurance coverage because they may never get insurance again, or the companies can refuse to cover the illness which causes them to be sick).

The federal bill gives states several choices of how to provide access to the individual market for these qualified folks. (The estimate we are talking about in Kansas is a maximum of between 1000 and 1500 Kansans a year). The debate in Kansas is between implementing the federal rules (our proposal in SB 204), and placing these Kansans in the high risk pool, (another choice for states under K/K).

S.B. 204 implements the "federal fallback" rules, which require each company writing individual insurance policies in Kansas to offer a choice of policies to "eligible" Kansans, without any pre-existing condition limitations. The bill contains no rate restrictions, so there are some eligible Kansans who will not be able to afford the individual policy premiums, and will still opt for the high risk pool, with some benefit limitation and rate restrictions.

We see the high risk pool is the "insurer of last resort" for those Kansans with no other option. For the current 940 members, it serves a useful purpose, and the funding mechanism makes sense. But Senator Kassebaum's bill has provided some VERY LIMITED individual market reform. For a small group of Kansans moving out of the group market, companies must offer a policy without any limitations. The federal law and our proposal has no rate restrictions, so there may be many eligible individuals who decide they can't afford the individual insurance and choose to be insured in the high risk pool. But they should have a choice. If we choose the "pool option", we have made no progress for these Kansans.

SUMMARY:
I see our actions in 1997 being a first step in reforming the individual health insurance market in Kansas. The ultimate goal is to make insurance more available and more affordable in the individual market, as we have done in the group market. We need an interim study and everyone at the table to reach a "more global solution", but these steps will help us get there.

Five years ago, when states began to pass market reforms for the group insurance market, there were dire predictions of skyrocketing rates and limited markets. That has not occurred.

In the 13 states which have already moved ahead on individual market reform, citizens have choices of insurance products, rates have not gone through the roof, and companies continue to write coverage. SB 204 is a very small step towards individual market reform in Kansas. If we fail to act this year, with the momentum of Senator Kassebaum's reform, I am fearful that Kansans will continue to be excluded from the private insurance market.

I am committed to working this summer on a plan which should include a "risk-sharing" mechanism, so we don't drive up rates in the individual market. I believe we have time to get that in place by July, 1998, when the first wave of eligible Kansans will be in the marketplace. I am hopeful that the Senate will approve SB 204.

Kansas Insurance Department
February 23, 1997
Draft No. 1

Session of 1997

SENATE BILL No. 204

By Committee on Financial Institutions and Insurance

2-4

AN ACT relating to accident and health insurance; group and individual policies of insurance; amending K.S.A. 1996 Supp. 40-2209, 40-2209d and 40-2209f and repealing the existing sections.

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

Section 1. K.S.A. 1996 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (A) *(1)* Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents. Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

(2) An eligible employee, member or dependent who requests enrollment following the open enrollment opportunity *or any special enrollment period for dependents as specified in subsection (3)* shall be considered a late enrollee. However, an eligible employee, member or dependent shall not be considered a late enrollee if:

~~(1)~~ *(a)* The individual:

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

~~(b)~~ *(ii)* states *in writing*, at the time of the open enrollment period, that coverage under another group policy which provided hospital, medical or surgical expense benefits was the reason for declining enrollment, *but only if the group policyholder ~~or certificateholder~~ or the accident and sickness insurer required such a written statement and provided the in-*

delete "or certificateholder"

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dividual with notice of the requirement for a written statement and the consequences of such written statement;

~~(c)~~ *(iii)* has lost coverage under another group policy providing hospital, medical or surgical expense benefits *or under section 607(1) of the employee retirement income security act of 1974 (ERISA)* as a result of the termination of employment the termination of the other policy's coverage, death of a spouse or divorce *or was under a COBRA continuation provision and the coverage under such provision was exhausted*; and

~~(d)~~ *iv* requests enrollment within ~~31~~ *30* days after the termination of coverage under the other policy; or

~~(2)~~ *(b)* a court has ordered coverage to be provided for a spouse or minor child under a covered employee's or member's policy.

(3) (a) If an accident and sickness insurer issues a group policy providing hospital, medical or surgical benefits and makes coverage available to a dependent of an eligible employee or member and such dependent becomes a dependent of the employee or member through marriage, birth, adoption or placement for adoption, then such group policy shall provide for a dependent special enrollment period as described in subsection (3)(b) of this section during which the dependent may be enrolled under the policy and in the case of the birth or adoption of a child, the spouse of an eligible employee or member may be enrolled if otherwise eligible for coverage.

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

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

(4) No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a *preexisting conditions* ~~waiting period~~ not to exceed 90 days for benefits for conditions~~, including related conditions, for which diagnosis, treatment or advice was sought or received in the 90 days prior to the effective date of coverage.~~ *(whether mental or physical), regardless of the cause of the condition for which*

reduction in the number of hours of employment, termination of employer contributions toward such coverage

or legal separation

(a)

delete "waiting period" and insert "exclusion"

following enrollment

medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of coverage. For the purposes of this section, the term "preexisting conditions ~~waiting period~~" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

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

(6) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition ~~waiting period~~ relating to pregnancy as a preexisting condition.

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

(8) Such policy shall waive such a *preexisting conditions* ~~waiting period~~ to the extent the employee or member or individual dependent or family member was covered by *(a)* a group or individual sickness and accident policy, *(b)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(c)* a group specified in K.S.A. 40-2222 and amendments thereto, *(d) part A or part B of title XVIII of the social security act, (e) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, (f) chapter 55 of title 10 United States code, (g) a medical care program of the indian health service or of a tribal organization, (h) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or a similar health benefits risk pool of another state, (i) a health plan offered under chapter 89 of title 5, United States code, (j) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e),* or *(k)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within ~~31~~ 63 days prior to the effective date of coverage with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in subsection (A)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection*

delete "(7)"

delete "waiting period" and insert "exclusion"

group

delete "(7)"

delete "subsection (b)(3)" and insert "subsections (D)(3) or (D)(4)"

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

(2) The certification described in this subsection is a written certification of (a) the period of coverage under a policy specified in subsection (A)[(7)] and any coverage under such COBRA continuation provision, and (b) any waiting period imposed with respect to the eligible employee, member or dependent for any coverage under such policy.

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

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

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

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

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

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

(d) if the accident and sickness insurer is ceasing to offer coverage such group market in accordance with [subsection ~~(b)~~(3);]

(e) in the case of accident and sickness insurer that offers coverage under a policy providing hospital, medical or surgical expense benefits

delete "a medical service" and insert "an"

delete "(D)(3) or (D)(5)" and insert "(F)(3) or (F)(5)"

delete "a particular" and insert "such"

delete "the type of" and insert "such"

through ~~a medical service~~ enrollment area, there is no longer any eligible employee, member or dependent in connection with such policy who lives, resides or works in the medical service enrollment area of the accident and sickness insurer (or in the area for which the accident and sickness insurer is authorized to do business); or

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

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

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

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

(c) in exercising the option to discontinue coverage and in offering the option of coverage under paragraph (b), the accident and sickness insurer acts uniformly without regard to the claims experience of those policyholders or certificateholders or any health status related factors relating to any eligible employee, member or dependent covered by such group policy or new employees or members who may become eligible for such coverage.

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

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

(b) all group policies providing hospital, medical or surgical expense benefits offered by such accident and sickness insurer are discontinued

and coverage under such policies are not renewed; and

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

(E) (1) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits may not establish rules for eligibility (including continued eligibility) of any employee, member or dependent to enroll under the terms of the group policy based on any of the following [~~health status related~~] factors in relation to the eligible employee, member or dependent: (a) Health status, (b) medical condition (including both physical and mental illness), (c) claims experience, (d) receipt of health care, (e) medical history, (f) genetic information, (g) evidence of insurability (including conditions arising out of acts of domestic violence), or (h) disability. This subsection shall ot be construed to require a policy providing hospital, medical or surgical expense benefits to provide particular benefits other than those provided under the terms of such group policy or to prevent a group policy providing hospital, medical or surgical expense benefits from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated individuals enrolled under the group policy.

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

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who is the policyholder, insuring at least [~~three~~] employees of such employer, for the benefit of persons other than the employer. The term "employees" shall include the officers, managers, employees and retired employees of the employer, the partners, if the employer is a partnership, the proprietor, if the employer is an individual proprietorship, the officers, managers and employees and retired employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, employees and retired employees of individuals and firms, the business of which and of the insured employer is under common control through stock ownership contract, or otherwise. The policy may provide that the term "employees" may include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

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

(3) Under a policy issued to the trustees of a fund established by two

delete "health status related"

delete "three" and insert "two"

security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987 to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights; or an employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because: (a) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (b) any discontinued group coverage was replaced by similar group coverage within 31 days; (c) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); or (d) the employee or member is or could be covered to the same extent by any other insured or lawful self-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection ~~(D)~~ [*(H)*] in lieu of the right to continue group coverage.

delete "(H)" and insert "(I)"

The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to subsection ~~(D)(21)(b)(ii)~~ [*(H)(21)(b)(ii)*]

delete "(H)(21)(b)(ii)" and insert "(I)(21)(b)(ii)"

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

(3) The terminated employee or member shall pay to the insurer the premium for the six-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage shall be such that can be expected

not less than three months if the deductible is $100 or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum benefit is determined by paragraph (a)(i) above or 24 months when the maximum benefit is determined by paragraph (a)(ii) above.

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

~~(12)~~ *(11)* The conversion privilege required by this act shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in ~~conditions (10) and (11)~~ *condition 10*. At the option of the insurer, such plans of benefits may be provided under one policy.

The insurer may also, in lieu of the plans of benefits set forth in ~~conditions (10) and (11)~~ *condition 10*, provide a policy of comprehensive medical expense benefits without first dollar coverage. The policy shall conform to the requirements of condition ~~(11)~~. An insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100, a high deductible option between $500 and $1,000, and a third deductible option midway between the high and low deductible options.

delete "(11)" and insert "(10)"

~~(13)~~ *(12)* The insurer, at its option, may also offer alternative plans for group health conversion in addition to those required by this act.

~~(14)~~ *(13)* In the event coverage would be continued under the group policy on an employee following the employee's retirement prior to the time the employee is or could be covered by medicare, the employee may elect, in lieu of such continuation of group insurance, to have the same conversion rights as would apply had such person's insurance terminated at retirement by reason of termination of employment or membership.

~~(15)~~ *(14)* The converted policy may provide for reduction of coverage on any person upon such person's eligibility for coverage under medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

~~(16)~~ *(15)* Subject to the conditions set forth above, the continua and conversion privileges shall also be available:

(a) To the surviving spouse, if any, at the death of the employee or

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

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

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

~~(17)~~ ~~If the benefit levels required in condition (10) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy either at the time the group policy was discontinued in its entirety and not replaced or as the group policy is in effect at the time the benefits under the converted policies are determined or redetermined in lieu of those required in condition (10).~~

~~(18)~~ *(16)* The insurer may elect to provide group insurance coverage which complies with this act in lieu of the issuance of a converted individual policy.

~~(19)~~ *(17)* A notification of the conversion privilege shall be included in each certificate of coverage.

~~(20)~~ *(18)* A converted policy which is delivered outside this state must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

~~(21)~~ *(19)* The insurer shall give the employee or member and such employee's or member's covered dependents: (a) Reasonable notice of the right to convert at least once during the six-month continuation period; or (b) for persons covered under 29 U.S.C. 1161 et seq., notice of the right to a conversion policy required by this subsection (D) shall be given at least 30 days: (i) Prior to the end of the continuation period provided by 29 U.S.C. 1161 et seq., or (ii) from the date the employer ceases to provide any similar group health plan to any employee. Such notices shall be provided in accordance with rules and regulations adopted by the commissioner of insurance.

delete "(I)" and insert "(J)"

~~(E)~~ [~~(I)~~] (1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts cov-

delete "(J)" and insert "(K)"

delete "may promulgate rules and regulations necessary to carry out the intent of this section." and insert "is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section."

erage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

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

[(J)] *The commissioner* ~~*may promulgate rules and regulations necessary to carry out the intent of this section.*~~

Sec. 2. K.S.A. 1996 Supp. 40-2209d is hereby amended to read as follows: 40-2209d. As used in this act:

(a) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of K.S.A. 40-2209h and amendments thereto, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Approved service area" means a geographical area, as approved by the commissioner to transact insurance in this state, within which the carrier is authorized to provide coverage.

(c) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(d) "Basic small employer health care plan" means a health benefit plan developed by the board pursuant to K.S.A. 40-2209k and amendments thereto.

(e) "Board" means the board of directors of the program.

(f) "Carrier" or "small employer carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, and pharmacy service corporations, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined by the Kansas Statutes Annotated, that offers health benefit plans covering eligible employees of one or more small employers in this state.

(g) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees reside; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier, and the number of employees and dependents and such other objective criteria as may be approved family composition by the commissioner. "Case characteristics" shall include claim experience, health status and duration of coverage si. issue.

(q) "Late enrollee" means an eligible employee or dependent who requests enrollment in a small employer's health benefit plan following the initial enrollment period provided under the terms of the first plan for which such employee or dependent was eligible through such small employer, however an eligible employee or dependent shall not be considered a late enrollee if:

(1) the individual:

(A) Was covered under another employer-provided health benefit plan *or was covered under section 607(1) of the employee retirement income security act of 1974 (ERISA)* at the time the individual was eligible to enroll;

(B) states *in writing*, at the time of the initial eligibility, that coverage under another employer health benefit plan was the reason for declining enrollment *but only if the group policyholder* ~~or certificateholder~~ *or the accident and sickness issuer required such a written statement and provided the individual with notice of the requirement for a written statement and the consequences of such written statement*;

(C) has lost coverage under another employer health benefit plan *or under section 607(1) of the employee retirement income security act of 1974 (ERISA)* as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(D) requests enrollment within ~~31~~ 63 days after the termination of coverage under another employer health benefit plan; or

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(3) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan.

(r) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(s) "Plan of operation" means the articles, bylaws and operating rules of the program adopted by the board pursuant to K.S.A. 40-2209l and amendments thereto.

(t) "Preexisting conditions ~~provision~~" means a policy provision which excludes or limits coverage for charges or expenses incurred during a specified period not to exceed 90 days following the insured's effective date of coverage as to a condition ~~or related conditions~~ *(whether physical or mental), regardless of the cause of the condition* for which diagnosi *care or* treatment ~~or advice was sought~~ *was recommended* or received the six months immediately preceding the effective date of coverage.

delete "or certificateholder"

reduction in the number of hours of employment, termination of employer contributions toward such coverage

or legal separation

exclusion

11-3

(u) "Premium" means moneys paid by a small employer or eligible employees or both as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(v) "Program" means the Kansas small employer health reinsurance program, established under K.S.A. 40-2209l and amendments thereto.

(w) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect but any period of less than one year shall be considered as a full year.

(x) "SEHC plan" means the Kansas small employer health care plan which shall be a health benefit plan for small employers established by the board in accordance with K.S.A. 40-2209k and amendments thereto.

(y) "~~Service waiting period~~" means a period of time after full-time employment begins before an employee is first eligible to enroll in any applicable health benefit plan offered by the small employer.

(z) "Small employer" means any person, firm, corporation, partnership or association eligible for group sickness and accident insurance pursuant to subsection (A) of K.S.A. 40-2209 and amendments thereto actively engaged in business whose total employed work force consisted of, on at least 50% of its working days during the preceding year, *of at least* ~~one~~ *and* no more than 50 eligible employees, the majority of whom were employed within the state. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, provisions of this act which apply to a small employer which has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

(aa) "Standard small employer health care plan" means a basic SEHC plan with specified benefit enhancements and such deductible and coinsurance provisions as may be developed by the board pursuant to K.S.A. 40-2209k and amendments thereto.

(bb) "Affiliate" or "affiliated" means an entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

Sec. 3. K.S.A. 1996 Supp. 40-2209f is hereby amended to read as follows: 40-2209f. Health benefit plans covering small employers that are issued or renewed within this state or outside this state covering persons residing in this state shall be subject to the following provisions, as applicable:

(a) Provisions of preexisting conditions shall not exclude or limit coverage for a period beyond 90 days following the individual's effective date of coverage and may only relate to conditions ~~or related conditions for~~

delete "Service waiting period" and insert "Waiting period"

delete "one" and insert "two"

which diagnosis, advice or treatment was sought *(whether physical or mental) regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received*, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a *preexisting conditions* waiting period not to exceed 90 days for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought *(whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended* or received in the six months prior to the effective date of coverage. On and after May 1, 1994, Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by *(1)* a group or individual sickness and accident policy, *(2)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(3)* a group specified in K.S.A. 40-2222 and amendments thereto or *(4) part A or part B of title XVIII of the social security act, title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, chapter 55 of title 10 United States code, (5) medical care program of the indian health service or of a tribal organization, (6) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or similar health benefits risk pool of another state, (7) a health plan offered under chapter 89 of title 5, United States code, (8) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504 (e) or (9)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within 31 *63* days prior to the effective date of coverage under a health benefit plan with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in this subsection without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall* not *be taken into account in determining the continuous period under this subsection.*

(c) Any health benefit plan issued, delivered or renewed within this state and subject to this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder or small employer, except for:

(1) Nonpayment of the required premiums by the policyholder, contractholder, or employer; or

(2) fraud or misrepresentation of the policyholder, contractholder, or employer or, with respect to coverage of individual insureds, the insured or their representatives; or

(3) noncompliance with health benefit plan provisions; or

delete "waiting period" and insert "preexisting conditions exclusion

delete "not"

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~~(4) when the total number of insured individuals covered under all of the health benefit plans of any one employer is less than the total number of individuals or percentage of individuals required by participation requirements under any specific health benefit plan of that employer; or~~

~~(5) when a material and significant change in the risk characteristics of the group has occurred because the small employer is no longer actively engaged in the business in which it was engaged on the policy's effective date; or~~

~~(6) when the carrier ceases doing business in the small employer market, if the following conditions are met:~~

~~(A) Notice of the decision to cease to do business in the small employer market is provided to the department, the board, to either the policyholder or contractholder, and the employer;~~

~~(B) health benefit plans subject to this act shall not be canceled by the carrier for one year after the date of the notice required under provision (A) unless the business has been sold to another carrier; and~~

~~(C) a carrier that ceases to do business in the small employer marketplace is prohibited from re-entering the small employer marketplace for five years from the date of the notice required under provision (A).~~

~~(d) Notwithstanding subsection (c) pertaining to renewability, any such health benefit plan or any coverage provided to any individual covered by such a plan subject to this act may be rescinded for fraud, material misrepresentation or concealment by an applicant, employee, dependent or small employer.~~

delete subsection (c) and reletter remaining subsections

~~(e) (c) A carrier shall not exclude any employee or dependent, who would otherwise be covered under a health benefit plan on the basis of an actual or expected health condition of such person, but a carrier shall be allowed to exclude a late enrollee.~~

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

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

~~(h)~~ *(f)* In the absence of the small employer's decision to the contrary, all health benefit plans shall make coverage available to all the eligible employees of a small employer without a waiting period. The decision of whether to impose a waiting period for eligible employees of a small employer shall be made by the small employer, who may only choose from the waiting periods offered by the carrier. No waiting period shall

be greater than 90 days and shall permit coverage to become effective no later than the first day of the month immediately following completion of the waiting period.

~~(i)~~ *(g)* The benefit structure of any health benefit plan subject to this act may be changed by the carrier to make it consistent with the benefit structure contained in health benefit plans developed by the board for marketing to new groups but this shall not preclude the development and marketing of other health benefit plans to small employers.

~~(j)~~ *(h)* (1) Except as provided in subsection (h), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

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

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

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

New Sec. 4. (a) On and after July 1, 1997, and subject to any exclusions set out in subsections (b) through (e), each accident and sickness insurer that offers ~~or renews~~ policies providing hospital, medical or surgical expense benefits to a small employer must: (1) Accept every small employer that applies for such coverage; and (2) accept for enrollment all eligible employees or dependents under such policy who apply for enrollment during the period in which the eligible employee or dependent first becomes eligible to enroll under the terms of the policy.

(b) (1) In the case of an accident and health insurer that offers a policy providing hospital, medical or surgical expense benefits to a small employer through a medical service enrollment area the accident and health insurer may:

(A) Limit the small employers that may apply for such cover[illegible] those with eligible employees or dependents who live, work or reside in the medical service enrollment area for such policy; and

Insert a new Section 4. to amend K.S.A. 1996 Supp. 40-3209 (health maintenance organizations) and revise subsections (c) and (e) of that statute as follows:

(c) [last sentence of paragraph] In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (12), (13), (14), (15), (16), and (18)~~, (19) and (20)~~ of subsection ~~(D)~~ (I) of K.S.A. 40-2209, and amendments thereto;

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

Insert a new Section 5. and incorporate the provisions of 1997 S.B. 47 which amends K.S.A. 40-2228 to make changes to the requirements for long term care insurance contracts.

Renumber the remaining sections of S.B. 204

delete "or renews"

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of the nonpayment of premiums or fraud;

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) As used in this section, "prior creditable coverage" means coverage by: (1) A group or individual accident and sickness policy; (2) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA); (3) a group specified in K.S.A. 40-2222 and amendments thereto; (4) part A or part B of title XVIII of the social security act; (5) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928; (6) chapter 55 of title 10 United States code; (7) a medical care program of the indian health service or of a tribal organization; (8) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2117 *et seq.* and amendments thereto or a similar health benefits risk pool of another state; (9) a health plan offered under chapter 89 of title 5, United States code; (10) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e); or (11) a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto.

(d) As used in this section "preexisting condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage.

(e) As used in this section "preexisting condition waiting period" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(f) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers the policy forms for such individual coverage with the largest, and the next to largest, premium volume of all such policy forms offered by the insurer in this state or the applicable marketing ~~or service~~ area by the accident and sickness insurer in the individual market in the period involved.

delete "or service"

(g) (1) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers a lower-level coverage policy form, as defined in subsection (g)(2), and a higher-level policy form, as defined in subsection (g)(3), each

2-16

Add a new section (n) to read as follows and reletter the remaining subsections:

(n) An accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits on the individual market as provided in this section shall actively market such coverage to eligible individuals in the state.

(1) Except as provided in subsection (j)(1)(B)(i) of this section, no individual health insurance carrier, agent or broker shall, directly or indirectly, engage in the following activities:

(a) encourage or direct individuals to refrain from filing an application for coverage with the individual health insurance carrier because of the health status, claims experience, industry occupation or geographic location of the individual or

(b) encourage or direct individuals to seek coverage from another carrier because of the health status, claims experience, industry occupation or geographic location of the individual.

(2) The provisions of paragraph (1) of this subsection shall not apply with respect to information provided by an individual health insurance carrier to an individual regarding the established geographic service area or a restricted network provision of an individual health insurance carrier.

(c)(i) Except as provided in paragraph (2) of this subsection, no individual health insurance carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to such person for the sale of a health benefit plan to be varied because of the health status, claims experience, industry occupation or geographic location of the individual placed by the agent or broker with the individual health insurance carrier.

(e) No individual health insurance carrier, agent or broker shall induce or otherwise exclude an individual from health coverage or benefits provided in connection with the individuals employment.

(f) Denial by an individual health insurance carrier of an application for coverage from an individual shall be in writing and shall state the reason or reasons for the denial.

(g) The commissioner may adopt rules and regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to individuals in this state.

(h) If an individual health insurance carrier enters into a contract, agreement or other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefits plans to individuals in this state, the third-party administrator shall be subject to this section as if it were an individual health insurance carrier.

and sickness insurer offers a conversion policy.

(n) Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that an accident and sickness insurer may charge an individual for a policy providing hospital, medical or surgical expense benefits in this state; or

(2) to prevent an accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(o) As used in this section, "health status-related factor" means: (1) A physical or mental illness medical condition; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information; (6) evidence of insurability including conditions arising out of acts of domestic violence; and (7) disability.

New Sec. 6. (a) Except as provided in this section, an accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits shall renew or continue in force such coverage at the option of the individual.

(b) An accident and sickness insurer may nonrenew or discontinue an individual policy providing hospital, medical or surgical expense benefits based only on one or more of the following:

(1) If the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the accident and sickness insurer has not received timely premium payments;

(2) if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) if the accident and sickness insurer is ceasing to offer individual policies providing hospital, medical or surgical expense benefits in accordance with subsection (c);

(4) in the case of accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits through a medical service enrollment area, if the individual no longer resides, lives or works in the medical service enrollment area (or in an area for which the accident and sickness insurer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(5) if the case of a policy providing hospital, medical or surgical expense benefits that is made available to individuals only through one or more bona fide associations, the membership of the individual in t
association (on the basis of which the coverage is provided) ceases b
only if such coverage is terminated under this paragraph uniformly with-

Additional changes to p. 28

delete "or rebates"

delete "a medical service" and insert "an"

and sickness insurer offers a conversion policy.

(n) Nothing in this section shall be construed:

(1) To restrict the amount of the premium rates that an accident and sickness insurer may charge an individual for a policy providing hospital, medical or surgical expense benefits in this state; or

(2) to prevent an accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits in the individual market from establishing premium discounts ~~or rebates~~ or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(o) As used in this section, "health status-related factor" means: (1) A physical or mental illness medical condition; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information; (6) evidence of insurability including conditions arising out of acts of domestic violence; and (7) disability.

New Sec. 6. (a) Except as provided in this section, an accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits shall renew or continue in force such coverage at the option of the individual.

(b) An accident and sickness insurer may nonrenew or discontinue an individual policy providing hospital, medical or surgical expense benefits based only on one or more of the following:

(1) If the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the accident and sickness insurer has not received timely premium payments;

(2) if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) if the accident and sickness insurer is ceasing to offer individual policies providing hospital, medical or surgical expense benefits in accordance with subsection (c);

(4) in the case of accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits through ~~a medical service~~ enrollment area, if the individual no longer resides, lives or works in the medical service enrollment area (or in an area for which the accident and sickness insurer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(5) if the case of a policy providing hospital, medical or surgical expense benefits that is made available to individuals only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly with-

STATE OF KANSAS

DIVISION OF THE BUDGET
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Bill Graves
Governor

Gloria M. Timmer
Director

February 19, 1997

The Honorable Don Steffes, Chairperson
Senate Committee on Financial Institutions and Insurance
Statehouse, Room 128-S
Topeka, Kansas 66612

Dear Senator Steffes:

SUBJECT: Fiscal Note for SB 204 by Senate Committee on Financial Institutions and Insurance

In accordance with KSA 75-3715a, the following fiscal note concerning SB 204 is respectfully submitted to your committee.

SB 204 amends and repeals specific sections of the law pertaining to insurance coverage. The bill effectively codifies the provisions of the Health Insurance Portability and Accountability Act (Kassabaum-Kennedy Bill) and the Mental Health Parity Act (MHPA), which recently became federal law. Major provisions of SB 204 are noted below:

1. The bill requires insurers to allow for a special enrollment period for dependents of eligible employees and specifies the date that the coverage is to be made available. The special enrollment period must last for at least 30 days. Dependents would include those who become a dependent of the employee or member through marriage, birth, adoption or placement for adoption.

2. SB 204 establishes restrictions on an insurer's requirements relating to preexisting conditions. Included in the reference of preexisting conditions are mental as well as physical conditions. Genetic information must not be treated as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information.

Senate FI & I
Attachment 3
2/25/97

3. The bill requires a plan sponsor to provide written certification, whenever required, of creditable coverage, when coverage ends for any group member. This written certification would also have to be provided for those with COBRA rights. Individuals with COBRA rights are those who lose eligibility because of divorce or who attain the maximum age of a dependent. This certification can be used by the individual in verifying credit for time insured, when the individual seeks insurance from another plan sponsor.

4. Participant requirements that may be imposed by a group policy as it relates to nonrenewal or discontinuance of coverage are noted in the bill. Included are situations such as failure to pay premiums or if fraudulent acts are performed by policy or certificate holders. The bill specifies notice requirements by which the insurer must abide.

5. Insurers are prohibited from excluding from benefits those with certain health or medical conditions, disabilities, or history of domestic abuse. Other factors that are protected are included in the bill.

6. A group health plan cannot impose one lifetime or annual dollar limit for medical and surgical benefits and a different limit for mental health benefits. A plan must either combine the mental health and medical and surgical benefits under a single annual and/or lifetime limit or create two separate but equal limits. Benefits for the treatment of substance abuse or chemical dependency are not considered mental health benefits.

7. The bill specifies that mental health requirements are not intended to affect plan provisions governing the amount, duration or scope of mental health benefits. A plan may still impose cost-sharing measures, medical-necessity requirements and limits on physician visits and days of coverage. Further, if compliance with the mental health parity requirements would result in an increase of 1.0 percent or more in a plan's costs, the requirements do not apply. The provisions of the bill relating to policies that include hospital, medical and surgical expense benefits and mental health benefits would apply to policies entered into or renewed after January 1, 1998. These provisions would not apply to benefits for services furnished on or after September 30, 2001.

According to the Kansas State Employees Health Care Commission, which administers the health insurance program for State of Kansas employees, provisions of SB 204 relating to preexisting conditions would not impact the State of Kansas' operations or responsibilities. The agency notes, however, that the written certification process will require programming changes to

the state's payroll system. These programming costs are estimated to be 124 hours at $40 per hour, for a cost of $4,960. This cost would be borne by the State General Fund. Mailing of the written certification is estimated to cost between $2,000 and $3,000. The Commission also states that staff would be needed to develop, implement and maintain the documentation system for written certification. No estimate on the number is provided at this time, however.

As it relates to the cost of the total health insurance program to the State of Kansas, the Commission asserts that increases in mental health benefits that were provided under the managed care options of the plan effective January 1, 1996, may mitigate the cost increases that might be associated with the mental health provisions of the bill. The Commission also submits that utilization has a potential for increasing, although there is no accurate way to determine the extent of the increase or the potential costs. Long-term fiscal effects would be directly tied to the potential increase of utilization patterns compounded by the medical inflation rate. Any additional costs associated with implementation of SB 204 are not reflected in *The FY 1998 Governor's Budget Report*.

Sincerely,

Gloria M. Timmer

Gloria M. Timmer
Director of the Budget

cc: Linda DeCoursey, Insurance Department
Terry Bernatis, Benefits, Department of Administration

in writing

(3) An accident and health insurer offering a policy providing hospital, medical or surgical expense benefits in both the group and individual markets shall notify a covered person of such insurer who is covered under a group policy under a COBRA continuation provision of the availability from such insurer of individual coverage not subject to underwriting or a new preexisting condition waiting period upon exhaustion of such COBRA continuation coverage.

Labeled
End 3 Sub para ch 3 after (B)

Page 28 of Bullens bottom of page

Senate Fin. A
attachment 4
2/25/97

MEMORANDUM

TO: The Honorable Don Steffes, Chairman
Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
The Health Insurance Association of America

DATE: February 24, 1997

RE: SB 204

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I appear today on behalf of the Health Insurance Association of America (HIAA), an association of more than 250 health insurance companies doing business in Kansas and nationwide. We appreciate this opportunity to present comments today on SB 204.

SB 204 is the Kansas Insurance Department's attempt to conform Kansas law with the mandates of the Kassebaum-Kennedy bill, also known as H.R. 3103, or the Health Insurance Portability and Accountability Act of 1996. For purposes of my testimony, I will refer to it as "K-K."

I would first like to state that HIAA is in complete agreement with 90% of the provisions in SB 204. Many of the provisions represent "technical" changes to Kansas law needed to comply with the federal mandate. As the issues unfolded in the subcommittee, however, it became apparent that there were two major points of contention between industry and the Department in regard to SB 204: 1) the Department's desire to define small groups as groups of 1-50; and 2) the Department's desire to implement the federal "fallback," or default, rules as Kansas' choice of an alternative mechanism in the individual market. The subcommittee ultimately decided to recommend that small groups be defined, as they are in K-K, as groups of 2-50. We support this position and thus will not engage in a lengthy discussion of that issue here.

The subcommittee also decided to take the Department's recommendation that Kansas implement the federal default rules as the state's alternative mechanism for the individual market under K-K. HIAA is adamantly opposed to this position for several reasons, all of which we have articulated to the subcommittee, some of which I would like to review with the full committee today.

The Department has presented the federal default rules as an alternative mechanism under K-K. Federal default was never meant to be an affirmative choice available to the states for bringing the individual market into compliance with K-K. According to the Conference Report/ Joint Explanatory Statement on K-K (Conference Report), the federal default rules would apply only if: 1) the state has not elected one of the alternative mechanisms; or 2) if the state mechanism does not meet the federal requirements. BNA Health Law Reporter, Vol. 5, No. 32, p. S-56 (1996). Federal default rules were never set up as an alternative mechanism.

Further, it is clear under the Congressional rules that the federal government may not impose mandates on the states without a funding source. The federal default rules, which includes a guaranteed issue mandate, were set up as a default mechanism--not an affirmative choice for the individual market--because K-K does not provide the funds for such a mandate. To get around the federal funding rule, the federal default provisions of K-K were set up merely as a default--not a mandate--therefore a funding source was not required.

Even if federal default were a legitimate alternative mechanism under K-K, it is one of the least desirable choices available under the bill. Essentially, the federal default rules dictate that once an individual has exhausted his or her opportunities is the group market, including COBRA, etc., the federally eligible individual is entitled to guaranteed issue of an individual health policy from the company of that individual's choice. The risk associated with that individual, which was formerly shared by a large number of people in the group insurance market, has then been transferred to a much smaller venue: the individual market--and more specifically--one company's share of the

individual market. The smallest risk-sharing population thus must bear the individual's health risk--and if that risk is large, and is shared by fewer people, each one sharing in the risk must pay more for health insurance. What happens when a disproportionate number of individuals coming from the group market demand guaranteed issue from a single company, or even a handful of companies? These companies are then left to shoulder considerable risks on the backs of fewer health plan participants.

The answer to this problem is to utilize the state's existing high risk pool, with a few minor alterations, as the alternative mechanism mandated by K-K. The Conference Report specifically dictates that states are not required to displace existing high risk pools. Unlike the federal default provisions, a qualified high risk pool is specifically listed as an acceptable alternative mechanism for the individual market in K-K. Further, states with a risk pool which currently offers qualified coverage is automatically considered to have met the federal mandates. I have provided a balloon in Attachment #1 which would amend SB 204 to eliminate the adoption of the federal default rules and instead modify the existing high risk pool to conform to K-K.

The greatest advantage to this approach is that it allows the risk associated with these individuals to be spread to the broadest base possible. Further, we believe that the risk pool is the best way to preserve current market stability. Kansas' high risk pool provides a workable alternative that would need little change to fit the mandates of K-K. It would be interesting to note the position of the various opponents to the high risk pool mechanism if the high risk pool were currently in 100% compliance with K-K. Would the high risk pool then be the mechanism of choice?

The best way to evaluate the merits of adopting the federal default rules versus adopting a modified high risk pool as the alternative mechanism is to step back and look at K-K from a broader view. The legislation was an attempt to balance the individual's need for portability of insurance coverage versus the realities of the marketplace. Part of that balance is the component of the

alternative mechanism--taking into careful consideration the choices available. The Department, however, is advocating a choice which is not really a choice but is something that is designed to be the worst-case scenario: the federal default provisions.

The Department has in fact cherry-picked certain provisions from K-K for the purposes of SB 204, while leaving other sections of Kansas law as-is. For example, if we were to truly attempt to conform Kansas law to the balance of the provisions of K-K, we would expand current Kansas law which provides only a 90-day pre-existing condition exclusion to 18 months, which is exactly what K-K provides. There are several other provisions of Kansas law which are similarly left alone by the Department's bill.

We are not advocating a return to a longer pre-ex waiting period; however, we would make the point that the spirit of K-K strikes a balance between the needs of the insurance consumer and the realities of the market. If the balance shifts too far either way, it is the consumer who ultimately pays. We believe that adoption of the federal default rules contravenes the letter and the spirit of K-K. We would argue that adoption of the high risk pool as an alternative mechanism is the only way to preserve market stability, thus guarding against a significant increase in premiums and protecting a diverse marketplace which fosters consumer choice.

Finally, I would offer two technical amendments to the Department's bill which clarify the interplay between pre-existing conditions exclusions and employer-imposed waiting periods. Attachments #2 and #3 clarify the provisions of the small group and large group laws by clarifying that any pre-existing conditions exclusion should run concurrently with any employer-imposed waiting period. This language would eliminate the employer's ability to get around K-K's pre-ex provisions by imposing a longer waiting period to accomplish the same goal. Attachment #2 also provides a definition of "waiting period."

In sum, we support in part and oppose in part the subcommittee's report on SB 204. We urge

your adoption of the amendment which would implement the high risk pool as an alternative mechanism and eliminate adoption of the federal default rules, and also of the technical amendments clarifying pre-ex and waiting periods.

Please feel free to contact me if you have any questions.

Respectfully submitted,

William W. Sneed

Attachment 1

K.S.A. 40-2209d and amendments thereto;

(2) "employee" means those persons as defined in subsection (1) of K.S.A. 40-2209d and amendments thereto;

(3) "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents;

(4) "group participation rule" means a requirement relating to the minimum number of employees and dependents that must be enrolled in relation to a specified percentage or number of eligible employees or dependents;

(5) "health status related factors" means: (A) a physical or mental illness medical condition, (B) claims experience, (C) receipt of health care, (D) medical history, (E) genetic information, (F) evidence of insurability including conditions arising out of acts of domestic violence and (H) disability; and

(6) "small employer" means those employers as defined by subsection (z) of K.S.A. 40-2209d and amendments thereto.

New Sec. 5. ~~(a) Each accident and sickness insurer that issues policies providing hospital, medical or surgical expense benefits on the individual market shall not, with respect to an eligible individual desiring to enroll in such policy: (1) Decline to offer such coverage to, or deny enrollment of such individual, or (2) impose any preexisting condition waiting period with respect to such coverage.~~

~~(b) As used in this section, "eligible individual" means an individual:~~

~~(1) (A) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months; and (B) whose most recent prior creditable coverage was under either: (i) A group policy providing hospital, medical or surgical expense benefits; (ii) a group policy under section 607(1) of the employee retirement income security act of 1974; (iii) a church plan under section 3(33) of the employee retirement income security act of 1974; (iv) a government plan under section 3(32) of the employee retirement income security act of 1974; or (v) a health plan established or maintained for its employees by the United States or by any agency or instrumentality of such government or coverage offered in connection with any such policy or plan;~~

~~(2) who is not eligible for coverage under: (A) A group health plan or policy as defined in subsection (b)(1)(A); (B) part A or part B of title XVIII of the social security act; or (C) a state plan under title XIX of such act (or any successor program), and does not have other coverage under a policy providing hospital, medical or surgical expense benefits;~~

~~(3) with respect to whom the most recent coverage within the cov-~~

K.S.A. 40-2118 is hereby amended to read as follows: 40-2118. 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 K.S.A. 40-2120.

(b) Association" means the Kansas health insurance association established in K.S.A. 40-2119.

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

(d) "Church plan" means a plan as defined under Section 3(33) of the Employee Retirement Income Security Act of 1974.

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

(f) "Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan.

(2) Health insurance coverage.

(3) Part A or Part B of Title XVIII of the Social Security Act.

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefit under Section 1928.

(5) Chapter 55 of Title 10, United States Code.

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefit risk pool.

(8) A health plan offered under Chapter 89 of Title 5, United States Code.

(9) A public health plan as defined under regulations promulgated by the Secretary of Health and Human Services.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d).

(g) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is

eighteen or more months and whose most recent prior coverage was under a group health plan, government plan or church plan;

(2) Who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act , or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(3) With respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(4) Who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.

(h) "Governmental plan" mans a plan as defined under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any plan maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(i) "Group health plan" means an employee benefit plan as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides any hospital, surgical or medial expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

~~(e)~~(j) "Health insurance" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health insurance" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-

payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

~~(g)~~(l) "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)~~(m) "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)~~(n) "Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.

~~(j)~~(o) "Medicare" mans coverage under both parts A and B of title XVIII of the federal social security act, 42 U.S.C. 1395.

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

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

~~(m)~~(r) "Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, by-laws and operating rules, adopted by the board pursuant to K.S.A. 40-2119.

Section 6. K.S.A. 1995 Supp. 40-2122 is hereby amended to read as follows: 40-2122. (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, and any federally defined eligible individual

who is a legal domiciliary of this state, 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.

(5) such person is a federally defined eligible individual.

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

(1) Any person who is eligible for Medicare or a recipient of 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, except that this provision shall not apply with respect to an applicant who is a federally defined eligible individual.

(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 K.S.A. 40-2124 and amendments thereto;

(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.

(d) All plan members, insurers and insurance arrangements shall notify in writing persons denied health insurance coverage, for any reason, of the availability of coverage through the Kansas health insurance association.

Section 7. K.S.A. 1995 Supp. 40-2124 is hereby amended to read as follows: 40-2124. (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 on 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. 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~~ $1,000,000 per covered individual.

(c) On and after May 1, 1994, coverage under the plan shall exclude charges or expenses incurred during the first 90 days following the effective date of coverage as to any condition: (1) Which manifested itself during the six-month period immediately prior to the application for coverage in such manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) 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 may be excluded as determined by the board, except that no such exclusion shall exceed 180 calendar days, and no exclusion shall be applied to a

federally defined eligible individual provided that application for coverage is made not later than 63 days following the applicant's most recent prior creditable coverage.

(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.

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of the nonpayment of premiums or fraud;

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) As used in this section, "prior creditable coverage" means coverage by: (1) A group or individual accident and sickness policy; (2) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA); (3) a group specified in K.S.A. 40-2222 and amendments thereto; (4) part A or part B of title XVIII of the social security act; (5) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928; (6) chapter 55 of title 10 United States code; (7) a medical care program of the indian health service or of a tribal organization; (8) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2117 *et seq.* and amendments thereto or a similar health benefits risk pool of another state; (9) a health plan offered under chapter 89 of title 5, United States code; (10) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e); or (11) a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto.

(d) As used in this section "preexisting condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage.

(e) As used in this section "preexisting condition waiting period" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(f) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers the policy forms for such individual coverage with the largest, and the next to largest, premium volume of all such policy forms offered by the insurer in this state or the applicable marketing or service area by the accident and sickness insurer in the individual market in the period involved.

(g) (1) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers a lower-level coverage policy form, as defined in subsection (g)(2), and a higher-level policy form, as defined in subsection (g)(3), each

of which includes benefits substantially similar to other individual health insurance coverage offered by the accident and sickness insurer and each of which is covered under a method which provides for risk adjustment, risk spreading or a risk spreading mechanism (among accident and sickness insurers in the individual market or individual policies providing hospital, medical or surgical expense benefits) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating accident and sickness insurers.

(2) A policy form provides a lower level of coverage if the actuarial value of the benefits under the coverage is at least 85% but not greater than 100% of a weighted average as described in subsection (g)(4).

(3) A policy form provides a higher level of coverage if:

(A) The actuarial value of the benefits under the coverage is at least 15% greater than the actuarial value of the coverage described in subsection (g)(4) offered by the accident and sickness insurer which offers such coverage; and

(B) the actuarial value of the benefits under the coverage is at least 100% but not greater than 120% of a weighted average described in subsection (g)(4).

(4) As used in this subsection, the weighted average is the average actuarial value of the benefits provided by all policies providing hospital, medical or surgical expense benefits issued (as elected by the accident and sickness insurer) either by that accident and sickness insurer or by all accident and sickness insurers which offered policies providing hospital, medical or surgical expense benefits in the individual market during the previous year (not including coverage issued under this subsection) weighted by enrollment for the different coverage.

(h) The election by an accident and sickness insurer for coverage under an individual policy providing hospital, medical or surgical expense benefits shall apply uniformly to all eligible individuals in this state for accident and health insurance. Such election shall be effective for policies offered during a period of not shorter than 2 years after the date such policies are approved by the commissioner.

(i) For the purposes of subsection (g), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(j) (1) In the case of an accident and sickness insurer that offers policies providing hospital, medical or surgical expense benefits in the individual market through a medical service enrollment area, the accident and sickness insurer may:

(A) Limit the individuals who may be enrolled under such coverage to those who live, reside or work within the medical service enrollment

area; and

(B) within the medical service enrollment area, deny such coverage to such individuals if the accident and sickness insurer has demonstrated, if required, to the commissioner that:

(i) It will not have the capacity to deliver services adequately to additional eligible individuals because of its obligations to existing group policyholders and certificateholders and group employees, members or dependents and to eligible individuals; and

(ii) it is applying this subsection uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An accident and sickness insurer, upon denying health insurance coverage in any medical service enrollment area in accordance with subsection (j)(1)(B)(ii), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(k) (1) An accident and sickness insurer may deny health insurance coverage in the individual market to an eligible individual if the accident and sickness insurer has demonstrated to the commissioner that:

(A) It does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this subsection uniformly to all individuals in the individual market in this state consistent with other provisions of this act and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An accident and sickness insurer upon denying individual health insurance coverage in any medical service enrollment area in accordance with subsection (k)(1) may not offer such coverage in the individual market within such medical service enrollment area for a period of 180 days after the date such coverage is denied or until the accident and sickness insurer has demonstrated to the commissioner under the provisions of the insurance code that such accident and sickness insurer has sufficient reserves to underwrite additional coverage, whichever is later.

(l) The provisions of subsection (a) shall not be construed to require that accident and sickness insurers which offer group policies providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209 and amendments thereto, must also offer such policies providing hospital, medical or surgical expense benefits in the individual market.

(m) An accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits through a conversion plan pursuant to K.S.A. 40-2209 and amendments thereto shall not be deemed to be an accident and sickness insurer offering individual policies providing hospital, medical or surgical expense benefits solely because such accident

~~and sickness insurer offers a conversion policy.~~

~~(n) Nothing in this section shall be construed:~~

~~(1) To restrict the amount of the premium rates that an accident and sickness insurer may charge an individual for a policy providing hospital, medical or surgical expense benefits in this state; or~~

~~(2) to prevent an accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.~~

~~(o) As used in this section, "health status related factor" means: (1) A physical or mental illness medical condition; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information; (6) evidence of insurability including conditions arising out of acts of domestic violence; and (7) disability.~~

New Sec. ~~6.~~ 8 (a) Except as provided in this section, an accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits shall renew or continue in force such coverage at the option of the individual.

(b) An accident and sickness insurer may nonrenew or discontinue an individual policy providing hospital, medical or surgical expense benefits based only on one or more of the following:

(1) If the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the accident and sickness insurer has not received timely premium payments;

(2) if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) if the accident and sickness insurer is ceasing to offer individual policies providing hospital, medical or surgical expense benefits in accordance with subsection (c);

(4) in the case of accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits through a medical service enrollment area, if the individual no longer resides, lives or works in the medical service enrollment area (or in an area for which the accident and sickness insurer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(5) if the case of a policy providing hospital, medical or surgical expense benefits that is made available to individuals only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly with-

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Attachment 2

medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of coverage. For the purposes of this section, the term "preexisting conditions ~~waiting period~~" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

Any preexisting conditions exclusion shall run concurrently with any waiting period.

(b) Such policy may impose a waiting period. "Waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in any applicable group policy.

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

(6) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition ~~waiting period~~ relating to pregnancy as a preexisting condition.

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

delete "(7)"

(8) Such policy shall waive such a *preexisting conditions* ~~waiting period~~ to the extent the employee or member or individual dependent or family member was covered by *(a)* a group or individual sickness and accident policy, *(b)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(c)* a group specified in K.S.A. 40-2222 and amendments thereto, *(d) part A or part B of title XVIII of the social security act, (e) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, (f) chapter 55 of title 10 United States code, (g) a medical care program of the indian health service or of a tribal organization, (h) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or a similar health benefits risk pool of another state, (i) a health plan offered under chapter 89 of title 5, United States code, (j) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e),* or *(k)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within ~~31~~ 63 days prior to the effective date of coverage with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in subsection (A)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection*

delete "waiting period" and insert "exclusion"

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Attachment 3

which diagnosis, advice or treatment was sought *(whether physical or mental) regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received*, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a *preexisting conditions* waiting period not to exceed 90 days for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought *(whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended* or received in the six months prior to the effective date of coverage. On and after May 1, 1994, Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by *(1)* a group or individual sickness and accident policy, *(2)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(3)* a group specified in K.S.A. 40-2222 and amendments thereto or *(4) part A or part B of title XVIII of the social security act, title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, chapter 55 of title 10 United States code, (5) medical care program of the indian health service or of a tribal organization, (6) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or similar health benefits risk pool of another state, (7) a health plan offered under chapter 89 of title 5, United States code, (8) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504 (e) or (9)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within 31 63 days prior to the effective date of coverage under a health benefit plan with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in this subsection without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.*

(c) Any health benefit plan issued, delivered or renewed within this state and subject to this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder or small employer, except for:

(1) Nonpayment of the required premiums by the policyholder, contractholder, or employer, or

(2) fraud or misrepresentation of the policyholder, contractholder, or employer or, with respect to coverage of individual insureds, the insureds or their representatives, or

(3) noncompliance with health benefit plan provisions, or

Any preexisting conditions exclusion shall run concurrently with any waiting period.

delete "waiting period" and insert "preexisting conditions exclusion

Such policy may impose a waiting period.

delete "not"

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MEMORANDUM

TO: The Honorable Don Steffes, Chairman
Senate Financial Institutions and Insurance Committee

FROM: William W. Sneed, Legislative Counsel
The Health Insurance Association of America

DATE: February 24, ~~1997~~ 25

RE: SB 204

Mr. Chairman, Members of the Committee: My name is Bill Sneed and I appear today on behalf of the Health Insurance Association of America (HIAA), an association of more than 250 health insurance companies doing business in Kansas and nationwide. We appreciate this opportunity to present comments today on SB 204.

SB 204 is the Kansas Insurance Department's attempt to conform Kansas law with the mandates of the Kassebaum-Kennedy bill, also known as H.R. 3103, or the Health Insurance Portability and Accountability Act of 1996. For purposes of my testimony, I will refer to it as "K-K."

I would first like to state that HIAA is in complete agreement with 90% of the provisions in SB 204. Many of the provisions represent "technical" changes to Kansas law needed to comply with the federal mandate. As the issues unfolded in the subcommittee, however, it became apparent that there were two major points of contention between industry and the Department in regard to SB 204: 1) the Department's desire to define small groups as groups of 1-50; and 2) the Department's desire to implement the federal "fallback," or default, rules as Kansas' choice of an alternative mechanism in the individual market. The subcommittee ultimately decided to recommend that small groups be defined, as they are in K-K, as groups of 2-50. We support this position and thus will not engage in a lengthy discussion of that issue here.

Senate FI&I
Attachment 5
Feb 25, 1997

The subcommittee also decided to take the Department's recommendation that Kansas implement the federal default rules as the state's alternative mechanism for the individual market under K-K. HIAA is adamantly opposed to this position for several reasons, all of which we have articulated to the subcommittee, some of which I would like to review with the full committee today.

The Department has presented the federal default rules as an alternative mechanism under K-K. Federal default was never meant to be an affirmative choice available to the states for bringing the individual market into compliance with K-K. According to the Conference Report/ Joint Explanatory Statement on K-K (Conference Report), the federal default rules would apply only if: 1) the state has not elected one of the alternative mechanisms; or 2) if the state mechanism does not meet the federal requirements. BNA Health Law Reporter, Vol. 5, No. 32, p. S-56 (1996). Federal default rules were never set up as an alternative mechanism.

Further, it is clear under the Congressional rules that the federal government may not impose mandates on the states without a funding source. The federal default rules, which includes a guaranteed issue mandate, were set up as a default mechanism--not an affirmative choice for the individual market--because K-K does not provide the funds for such a mandate. To get around the federal funding rule, the federal default provisions of K-K were set up merely as a default--not a mandate--therefore a funding source was not required.

Even if federal default were a legitimate alternative mechanism under K-K, it is one of the least desirable choices available under the bill. Essentially, the federal default rules dictate that once an individual has exhausted his or her opportunities is the group market, including COBRA, etc., the federally eligible individual is entitled to guaranteed issue of an individual health policy from the company of that individual's choice. The risk associated with that individual, which was formerly shared by a large number of people in the group insurance market, has then been transferred to a much smaller venue: the individual market--and more specifically--one company's share of the

individual market. The smallest risk-sharing population thus must bear the individual's health risk--and if that risk is large, and is shared by fewer people, each one sharing in the risk must pay more for health insurance. What happens when a disproportionate number of individuals coming from the group market demand guaranteed issue from a single company, or even a handful of companies? These companies are then left to shoulder considerable risks on the backs of fewer health plan participants.

The answer to this problem is to utilize the state's existing high risk pool, with a few minor alterations, as the alternative mechanism mandated by K-K. The Conference Report specifically dictates that states are not required to displace existing high risk pools. Unlike the federal default provisions, a qualified high risk pool is specifically listed as an acceptable alternative mechanism for the individual market in K-K. Further, states with a risk pool which currently offers qualified coverage is automatically considered to have met the federal mandates. I have provided a balloon in Attachment #1 which would amend SB 204 to eliminate the adoption of the federal default rules and instead modify the existing high risk pool to conform to K-K.

The greatest advantage to this approach is that it allows the risk associated with these individuals to be spread to the broadest base possible. Further, we believe that the risk pool is the best way to preserve current market stability. Kansas' high risk pool provides a workable alternative that would need little change to fit the mandates of K-K. It would be interesting to note the position of the various opponents to the high risk pool mechanism if the high risk pool were currently in 100% compliance with K-K. Would the high risk pool then be the mechanism of choice?

The best way to evaluate the merits of adopting the federal default rules versus adopting a modified high risk pool as the alternative mechanism is to step back and look at K-K from a broader view. The legislation was an attempt to balance the individual's need for portability of insurance coverage versus the realities of the marketplace. Part of that balance is the component of the

alternative mechanism--taking into careful consideration the choices available. The Department, however, is advocating a choice which is not really a choice but is something that is designed to be the worst-case scenario: the federal default provisions.

The Department has in fact cherry-picked certain provisions from K-K for the purposes of SB 204, while leaving other sections of Kansas law as-is. For example, if we were to truly attempt to conform Kansas law to the balance of the provisions of K-K, we would expand current Kansas law which provides only a 90-day pre-existing condition exclusion to 18 months, which is exactly what K-K provides. There are several other provisions of Kansas law which are similarly left alone by the Department's bill.

We are not advocating a return to a longer pre-ex waiting period; however, we would make the point that the spirit of K-K strikes a balance between the needs of the insurance consumer and the realities of the market. If the balance shifts too far either way, it is the consumer who ultimately pays. We believe that adoption of the federal default rules contravenes the letter and the spirit of K-K. We would argue that adoption of the high risk pool as an alternative mechanism is the only way to preserve market stability, thus guarding against a significant increase in premiums and protecting a diverse marketplace which fosters consumer choice.

Finally, I would offer two technical amendments to the Department's bill which clarify the interplay between pre-existing conditions exclusions and employer-imposed waiting periods. Attachments #2 and #3 clarify the provisions of the small group and large group laws by clarifying that any pre-existing conditions exclusion should run concurrently with any employer-imposed waiting period. This language would eliminate the employer's ability to get around K-K's pre-ex provisions by imposing a longer waiting period to accomplish the same goal. Attachment #2 also provides a definition of "waiting period."

In sum, we support in part and oppose in part the subcommittee's report on SB 204. We urge

your adoption of the amendment which would implement the high risk pool as an alternative mechanism and eliminate adoption of the federal default rules, and also of the technical amendments clarifying pre-ex and waiting periods.

Please feel free to contact me if you have any questions.

Respectfully submitted,

William W. Sneed

Attachment 1

K.S.A. 40-2209d and amendments thereto;

(2) "employee" means those persons as defined in subsection (1) of K.S.A. 40-2209d and amendments thereto;

(3) "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of employees and dependents;

(4) "group participation rule" means a requirement relating to the minimum number of employees and dependents that must be enrolled in relation to a specified percentage or number of eligible employees or dependents;

(5) "health status related factors" means: (A) a physical or mental illness medical condition, (B) claims experience, (C) receipt of health care, (D) medical history, (E) genetic information, (F) evidence of insurability including conditions arising out of acts of domestic violence and (H) disability; and

(6) "small employer" means those employers as defined by subsection (z) of K.S.A. 40-2209d and amendments thereto.

~~New Sec. 5. (a) Each accident and sickness insurer that issues policies providing hospital, medical or surgical expense benefits on the individual market shall not, with respect to an eligible individual desiring to enroll in such policy: (1) Decline to offer such coverage to, or deny enrollment of such individual, or (2) impose any preexisting condition waiting period with respect to such coverage.~~

~~(b) As used in this section, "eligible individual" means an individual:~~

~~(1) (A) For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months; and (B) whose most recent prior creditable coverage was under either: (i) A group policy providing hospital, medical or surgical expense benefits; (ii) a group policy under section 607(1) of the employee retirement income security act of 1974; (iii) a church plan under section 3(33) of the employee retirement income security act of 1974; (iv) a government plan under section 3(32) of the employee retirement income security act of 1974; or (v) a health plan established or maintained for its employees by the United States or by any agency or instrumentality of such government or coverage offered in connection with any such policy or plan;~~

~~(2) who is not eligible for coverage under: (A) A group health plan or policy as defined in subsection (b)(1)(A); (B) part A or part B of title XVIII of the social security act; or (C) a state plan under title XIX of such act (or any successor program), and does not have other coverage under a policy providing hospital, medical or surgical expense benefits;~~

~~(3) with respect to whom the most recent coverage within the cov-~~

K.S.A. 40-2118 is hereby amended to read as follows: 40-2118. 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 K.S.A. 40-2120.

(b) Association" means the Kansas health insurance association established in K.S.A. 40-2119.

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

(d) "Church plan" means a plan as defined under Section 3(33) of the Employee Retirement Income Security Act of 1974.

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

(f) "Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan.

(2) Health insurance coverage.

(3) Part A or Part B of Title XVIII of the Social Security Act.

(4) Title XIX of the Social Security Act, other than coverage consisting solely of benefit under Section 1928.

(5) Chapter 55 of Title 10, United States Code.

(6) A medical care program of the Indian Health Service or of a tribal organization.

(7) A state health benefit risk pool.

(8) A health plan offered under Chapter 89 of Title 5, United States Code.

(9) A public health plan as defined under regulations promulgated by the Secretary of Health and Human Services.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d).

(g) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is

eighteen or more months and whose most recent prior coverage was under a group health plan, government plan or church plan;

(2) Who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act , or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(3) With respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(4) Who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.

(h) "Governmental plan" mans a plan as defined under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any plan maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(i) "Group health plan" means an employee benefit plan as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides any hospital, surgical or medial expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

~~(e)~~(j) "Health insurance" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health insurance" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-

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

~~(g)~~(l) "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)~~(m) "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)~~(n) "Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.

~~(j)~~(o) "Medicare" mans coverage under both parts A and B of title XVIII of the federal social security act, 42 U.S.C. 1395.

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

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

~~(m)~~(r) "Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, by-laws and operating rules, adopted by the board pursuant to K.S.A. 40-2119.

Section 6. K.S.A. 1995 Supp. 40-2122 is hereby amended to read as follows: 40-2122. (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, and any federally defined eligible individual

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who is a legal domiciliary of this state, 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.

(5) such person is a federally defined eligible individual.

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

(1) Any person who is eligible for Medicare or a recipient of 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, except that this provision shall not apply with respect to an applicant who is a federally defined eligible individual.

(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 K.S.A. 40-2124 and amendments thereto;

(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.

(d) All plan members, insurers and insurance arrangements shall notify in writing persons denied health insurance coverage, for any reason, of the availability of coverage through the Kansas health insurance association.

Section 7. K.S.A. 1995 Supp. 40-2124 is hereby amended to read as follows: 40-2124. (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 on 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. 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~~ $1,000,000 per covered individual.

(c) On and after May 1, 1994, coverage under the plan shall exclude charges or expenses incurred during the first 90 days following the effective date of coverage as to any condition: (1) Which manifested itself during the six-month period immediately prior to the application for coverage in such manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) 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 may be excluded as determined by the board, except that no such exclusion shall exceed 180 calendar days, and no exclusion shall be applied to a

federally defined eligible individual provided that application for coverage is made not later than 63 days following the applicant's most recent prior creditable coverage.

(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.

of the nonpayment of premiums or fraud;

(4) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

(c) As used in this section, "prior creditable coverage" means coverage by: (1) A group or individual accident and sickness policy; (2) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA); (3) a group specified in K.S.A. 40-2222 and amendments thereto; (4) part A or part B of title XVIII of the social security act; (5) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928; (6) chapter 55 of title 10 United States code; (7) a medical care program of the indian health service or of a tribal organization; (8) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2117 *et seq.* and amendments thereto or a similar health benefits risk pool of another state; (9) a health plan offered under chapter 89 of title 5, United States code; (10) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e); or (11) a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto.

(d) As used in this section "preexisting condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage.

(e) As used in this section "preexisting condition waiting period" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

(f) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers the policy forms for such individual coverage with the largest, and the next to largest, premium volume of all such policy forms offered by the insurer in this state or the applicable marketing or service area by the accident and sickness insurer in the individual market in the period involved.

(g) (1) The requirement of this section is met, for a policy providing hospital, medical or surgical expense benefits offered by an accident and sickness insurer in the individual market, if the accident and sickness insurer offers a lower-level coverage policy form, as defined in subsection (g)(2), and a higher-level policy form, as defined in subsection (g)(3), each

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of which includes benefits substantially similar to other individual health insurance coverage offered by the accident and sickness insurer and each of which is covered under a method which provides for risk adjustment, risk spreading or a risk spreading mechanism (among accident and sickness insurers in the individual market or individual policies providing hospital, medical or surgical expense benefits) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating accident and sickness insurers.

(2) A policy form provides a lower level of coverage if the actuarial value of the benefits under the coverage is at least 85% but not greater than 100% of a weighted average as described in subsection (g)(4).

(3) A policy form provides a higher level of coverage if:

(A) The actuarial value of the benefits under the coverage is at least 15% greater than the actuarial value of the coverage described in subsection (g)(4) offered by the accident and sickness insurer which offers such coverage; and

(B) the actuarial value of the benefits under the coverage is at least 100% but not greater than 120% of a weighted average described in subsection (g)(4).

(4) As used in this subsection, the weighted average is the average actuarial value of the benefits provided by all policies providing hospital, medical or surgical expense benefits issued (as elected by the accident and sickness insurer) either by that accident and sickness insurer or by all accident and sickness insurers which offered policies providing hospital, medical or surgical expense benefits in the individual market during the previous year (not including coverage issued under this subsection) weighted by enrollment for the different coverage.

(h) The election by an accident and sickness insurer for coverage under an individual policy providing hospital, medical or surgical expense benefits shall apply uniformly to all eligible individuals in this state for accident and health insurance. Such election shall be effective for policies offered during a period of not shorter than 2 years after the date such policies are approved by the commissioner.

(i) For the purposes of subsection (g), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

(j) (1) In the case of an accident and sickness insurer that offers policies providing hospital, medical or surgical expense benefits in the individual market through a medical service enrollment area, the accident and sickness insurer may:

(A) Limit the individuals who may be enrolled under such coverage to those who live, reside or work within the medical service enrollment

area; and

(B) within the medical service enrollment area, deny such coverage to such individuals if the accident and sickness insurer has demonstrated, if required, to the commissioner that:

(i) It will not have the capacity to deliver services adequately to additional eligible individuals because of its obligations to existing group policyholders and certificateholders and group employees, members or dependents and to eligible individuals; and

(ii) it is applying this subsection uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An accident and sickness insurer, upon denying health insurance coverage in any medical service enrollment area in accordance with subsection (j)(1)(B)(ii), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

(k) (1) An accident and sickness insurer may deny health insurance coverage in the individual market to an eligible individual if the accident and sickness insurer has demonstrated to the commissioner that:

(A) It does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this subsection uniformly to all individuals in the individual market in this state consistent with other provisions of this act and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

(2) An accident and sickness insurer upon denying individual health insurance coverage in any medical service enrollment area in accordance with subsection (k)(1) may not offer such coverage in the individual market within such medical service enrollment area for a period of 180 days after the date such coverage is denied or until the accident and sickness insurer has demonstrated to the commissioner under the provisions of the insurance code that such accident and sickness insurer has sufficient reserves to underwrite additional coverage, whichever is later.

(l) The provisions of subsection (a) shall not be construed to require that accident and sickness insurers which offer group policies providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209 and amendments thereto, must also offer such policies providing hospital, medical or surgical expense benefits in the individual market.

(m) An accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits through a conversion plan pursuant to K.S.A. 40-2209 and amendments thereto shall not be deemed to be an accident and sickness insurer offering individual policies providing hospital, medical or surgical expense benefits solely because such accident

~~and sickness insurer offers a conversion policy.~~

~~(n) Nothing in this section shall be construed:~~

~~(1) To restrict the amount of the premium rates that an accident and sickness insurer may charge an individual for a policy providing hospital, medical or surgical expense benefits in this state; or~~

~~(2) to prevent an accident and sickness insurer offering policies providing hospital, medical or surgical expense benefits in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.~~

~~(o) As used in this section, "health status related factor" means: (1) A physical or mental illness medical condition; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information; (6) evidence of insurability including conditions arising out of acts of domestic violence; and (7) disability.~~

New Sec. 6. 8 (a) Except as provided in this section, an accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits shall renew or continue in force such coverage at the option of the individual.

(b) An accident and sickness insurer may nonrenew or discontinue an individual policy providing hospital, medical or surgical expense benefits based only on one or more of the following:

(1) If the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the accident and sickness insurer has not received timely premium payments;

(2) if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) if the accident and sickness insurer is ceasing to offer individual policies providing hospital, medical or surgical expense benefits in accordance with subsection (c);

(4) in the case of accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits through a medical service enrollment area, if the individual no longer resides, lives or works in the medical service enrollment area (or in an area for which the accident and sickness insurer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(5) if the case of a policy providing hospital, medical or surgical expense benefits that is made available to individuals only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly with-

Attachment 2

medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of coverage. For the purposes of this section, the term "preexisting conditions ~~waiting period~~" shall mean, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.

Any preexisting conditions exclusion shall run concurrently with any waiting period.

(b) Such policy may impose a waiting period. "Waiting period" means a period of time after full-time employment begins before an employee is first eligible to enroll in any applicable group policy.

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

(6) A group policy providing hospital, medical or surgical expense benefits may not impose any preexisting condition ~~waiting period~~ relating to pregnancy as a preexisting condition.

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

delete "(7)"

(8) Such policy shall waive such a *preexisting conditions* ~~waiting period~~ to the extent the employee or member or individual dependent or family member was covered by *(a)* a group or individual sickness and accident policy, *(b)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(c)* a group specified in K.S.A. 40-2222 and amendments thereto, *(d) part A or part B of title XVIII of the social security act, (e) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, (f) chapter 55 of title 10 United States code, (g) a medical care program of the indian health service or of a tribal organization, (h) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or a similar health benefits risk pool of another state, (i) a health plan offered under chapter 89 of title 5, United States code, (j) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504(e),* or *(k)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within ~~31~~ 63 days prior to the effective date of coverage with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in subsection (A)(7) without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.*

delete "waiting period" and insert "exclusion"

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Attachment 3

which diagnosis, advice or treatment was sought *(whether physical or mental) regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received*, during the six months immediately preceding the effective date of coverage.

(b) Such policy may impose a *preexisting conditions* waiting period not to exceed 90 days for benefits for conditions, including related conditions, for which diagnosis, treatment or advice was sought *(whether physical or mental), regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended* or received in the six months prior to the effective date of coverage. On and after May 1, 1994, Such policy shall waive such a waiting period to the extent the employee or member or individual dependent or family member was covered by *(1)* a group or individual sickness and accident policy, *(2)* coverage under section 607(1) of the employees retirement income *security* act of 1974 (ERISA), *(3)* a group specified in K.S.A. 40-2222 and amendments thereto or *(4) part A or part B of title XVIII of the social security act, title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, chapter 55 of title 10 United States code, (5) medical care program of the indian health service or of a tribal organization, (6) the Kansas uninsurable health plan act pursuant to K.S.A. 40-2217 et seq. and amendments thereto or similar health benefits risk pool of another state, (7) a health plan offered under chapter 89 of title 5, United States code, (8) a health benefit plan under section 5(e) of the peace corps act (22 U.S.C. 2504 (e) or (9)* a group subject to K.S.A. 12-2616 *et seq.* and amendments thereto which provided hospital, medical and surgical expense benefits within 31 63 days prior to the effective date of coverage under a health benefit plan with no gap in coverage. *A group policy shall credit the periods of prior coverage specified in this subsection without regard to the specific benefits covered during the period of prior coverage. Any period that the employee or member is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under this subsection.*

(c) Any health benefit plan issued, delivered or renewed within this state and subject to this act, shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, contractholder or small employer, except for:

(1) Nonpayment of the required premiums by the policyholder, contractholder, or employer, or

(2) fraud or misrepresentation of the policyholder, contractholder, or employer or, with respect to coverage of individual insureds, the insureds or their representatives; or

(3) noncompliance with health benefit plan provisions; or

Any preexisting conditions exclusion shall run concurrently with any waiting period.

delete "waiting period" and insert "preexisting conditions exclusion

Such policy may impose a waiting period.

delete "not"

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