Approved: February 2, 2000
Date

MINUTES OF THE SENATE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Senator Don Steffes at 9:00 a.m. on January 26, 2000 in Room 529-S of the Capitol.

All members were present except: Senator Sandy Praeger, Excused

Committee staff present: Dr. William Wolff, Legislative Research
Ken Wilke, Office of Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Linda DeCoursey, Kansas Insurance Department
Dennis Wilson, Office of State Treasurer

Others attending: (See Attached)

**Action on SB 444–Insurance, mortgage guaranty insurance companies; concerning authorized real estate security**
Senator Feleciano moved that **SB 444** be recommended for favorable passage by the Committee. The motion was seconded by Senator Brownlee. Motion carried.

**Action on SB 412 - Bank commissioner, rules and regulations , correction of statutory reference**
Senator Feleciano moved that **SB 412** be recommended for favorable passage by the Committee. The motion was seconded by Senator Barone. Motion carried.

Dennis Wilson, representing the Office of the State Treasurer, asked for the introduction of legislation which addresses an updating in procedures of their office (electronic filing).

Senator Brownlee moved that the proposal be introduced into legislation. Motion was seconded by Senator Becker. Motion carried.

**Hearing on SB 441–Health insurance; removing sunset on 1997 amendments required by HIPAA**
Linda DeCoursey, Kansas Insurance Department, reported there have been no policy changes since the Legislature passed **SB 204** in 1997 (Attachment 1). She described the areas of Kansas statute which had been impacted by the federal health care bill HR 3103 Kassebaum/Kennedy or Health Insurance Portability Accountability Act (HIPAA). Kansas chose to develop a state alternative mechanism (SAM) and used the Uninsurable Health Insurance Plan or high risk pool. Those states who chose the SAM's have had the least amount of problems in the implementation of the federal plan. In legislation passed by the 1997 Session, a sunset of January 1, 2001, was inserted in the statute. This language must be struck in order to make the amendments to the plan permanent. If this sunset is not struck, HCFA would "most likely be our new best friends." Also technical changes deleting references to a board that was deleted from the statutes several years ago are requested.

Mrs. DeCoursey was asked to furnish to the Committee information on the High Risk Pool regarding enrollment numbers, effectiveness, service providers, cost of service, solvency, and projections of future enrollment and costs.

The hearing was closed on **SB 441.**

**Hearing on SB 440–Insurance; risk-based capital requirements**
Linda DeCoursey, Kansas Insurance Department, explained that this bill makes a change to the law dealing with the filing of financial reports by insurance companies with the Department (Attachment 2). Current law requires companies to use the 1998 version of the RBC instructions. The bill would reflect a change in the date of the standard so that carriers use the RBC formulas in effect as of December 31, 1999.

Dave Hanson, Kansas Insurance Associations, presented written testimony supporting the proposed legislation (Attachment 3).

The hearing was closed on **SB 440.**

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

**SENATE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE**
**GUEST LIST**
**DATE:** 1/26

| NAME | REPRESENTING |
|---|---|
| John Federico | Humana |
| Nicole Basso | Kansas Ins. Dept |
| Amanda Small | Kansas Ins DEPT |
| Kevin Barone | Hein/Weir Chtd. |
| Larrie Ann Lower | KAHP |
| Bill Sneed | MEIC |
| DENNIS WILSON | STATE TREASURER |
| David Hanson | Ks Insur Assns. |
| Chip Wheelen | Assn of Osteo. Med. |
| Kevin Davis | Am. Family Ins. |
| Marc Hamann | Div. of the Budget |
| Linda DeCoursey | KS Insurance Dept |
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**Kathleen Sebelius**
Commissioner of Insurance
**Kansas Insurance Department**

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda De Coursey, Director of Government Affairs

RE: SB 441 – HIPAA – High Risk Pool Amendments Sunset

DATE: January 26, 2000

Mr. Chairman and members of the committee:

Thank you for allowing me the opportunity to discuss with you SB 441. In 1996, Congress passed a little health care bill called HR 3103 or Kassebaum/Kennedy, or Health Insurance Portability Accountability Act or HIPAA. In Kansas, the implementation of the federal law was codified in SB 204 or Chapter 190 of the 1997 Session Laws, and now in various statutes.

Several areas of the Kansas statutes had to be changed in order to comply with HIPAA's sweeping changes. Changes were made to group coverage for sickness and accident statutes for both large group and small employer groups (KSA 40-2209 et seq.) HMO statutes (KSA 40-3209) were changed; long-term care statutes (KSA 40-2228); mental health coverage (KSA 40-2,105) and medical savings accounts were added. These changes included guaranteed availability, late enrollees, special 30 day enrollment, waiting periods, and pre-existing conditions, such as genetic information, pregnancy and not imposing a pre-ex on adopted children. And, let's not forget prior creditable coverage and the 63 day gap, and looking forward and looking back, and a federally defined eligible individual.

One of the decisions that states had to make was to use the individual market or develop a state alternative mechanism (SAM). Kansas chose the SAM route, and used the Uninsurable Health Insurance Plan or high risk pool. I have attached the high risk pool statutes (KSA 40-2117 through 40-2131) and as you will see, they are color-coded.

- Red indicates the changes made to the high risk pool by SB 204 or Chapter 190 of the 1997 Session laws that are a direct result of HIPAA requirements.

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- Black bolded areas (not including titles) indicates the changes made to the high risk pool at that same time, but were not a direct result of HIPAA requirements.
- Teal indicates a change made the following year in the clean up amendments regarding HIPAA requirements.

It is in KSA 40-2121(c) that the following sunset is found: *The amendments made to the Kansas uninsurable health insurance plan act by chapter 190 of the 1997 Session Laws of Kansas shall expire on January 1, 2001.* In SB 441, we are striking the sunset languag, which will make the amendments to the plan permanent.

What happens if we don't strike the language? All amendments, HIPAA related or not, expires on January 1 of next year, and HCFA personnel will most likely be our new best friends. Some of the HCFA personnel reminded me recently that any changes regarding HIPAA implementation must be approved by them first.

Some discussions have occurred with interested parties about leaving the sunset on and revisiting the high risk pool every two or three years. I really don't think that's direction to take. HCFA has studied the individual market states and the states with SAMs. The least problems are found in the SAM states. Clearly, they have worked better. And, to reiterate my previous statement, any changes to HIPAA must be approved by HCFA. As I indicated earlier, many other Kansas statutes were changed for HIPAA implementation, and have been law with no sunset provision all this time. If, in fact, the interest lies in the other amendments, but not HIPAA requirements, then those amendment are not any different than any other amendment placed on Kansas statutes.

The second portion of SB 441 includes technical changes deleting references to board that was deleted from the statutes several years ago.

Thank you again for allowing me this opportunity to discuss SB 441. I would respectfully ask for your favorable consideration of this bill.

# 40-2117

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2117. Uninsurable health insurance plan; citation of act.** This act shall be known and may be cited as the Kansas uninsurable health insurance plan act.

**History:** L. 1992, ch. 209, § 1; July 1.

# 40-2118

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2118. Same; definitions.** 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, and amendments thereto.

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

(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.**

(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; and**

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

**(g) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 23 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.**

**(h) "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 18 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.**

(i) "Excess loss" means the total dollar amount by which claims expense incurred for any issuer of a medicare supplement policy or certificate delivered or issued for delivery to persons in this state eligible for medicare by reason of disability and who are under age 65 exceeds 65% of the premium earned by such issuer during a calendar year.

**(j) "Governmental plan" means 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.**

**(k) "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 medical expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.**

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

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

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

(n) "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.

(o) "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.

(p) "Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.
(q) "Medicare" means coverage under both parts A and B of title XVIII of the federal social security act, 42 USC 1395.

(r) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospitals and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 USC 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

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

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

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

**History:** L. 1992, ch. 209, § 2; **L. 1997, ch. 190**, § 7; L. 1999, ch. 106, § 1; July 1.

# 40-2119

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2119. Same; Kansas health insurance association, membership, board of directors; plan of operation, approval of commissioner; powers and duties of association; reinsurance program for medicare supplement policies.** (a) There is hereby created a nonprofit legal entity to be known as the Kansas health insurance association. All insurers and insurance arrangements providing health care benefits in this state shall be members of the association. The association shall operate under a plan of operation established and approved under subsection (b) of this section and shall exercise its powers through a board of directors established under this section.

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

(2) The board shall submit to the commissioner a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if it is determined to be suitable to assure the fair, reasonable and equitable administration of the plan and provides for the sharing of association losses on an equitable proportionate basis among the members of the association. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this section. Such rules and regulations shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

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

(B) select an administering carrier in accordance with K.S.A. 40-2120, and amendments thereto;

(C) establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to K.S.A. 40-2121, and amendments thereto. Assessments shall be due and payable within 30 days of receipt of the assessment notice;

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

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

**(F) Establish benefit levels, lifetime maximum benefits, and other coverage and eligibility parameters, and establish such other requirements and procedures as are necessary to assure the availability of a benefit program or programs conforming with the requirements of a qualified high risk pool as set forth in section 111 of Public Law 104-191 and amendments thereto.**

(c) The association shall have the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (b). The association shall have the general powers and authority granted under the laws of this state to insurers licensed to transact the kind of health service or insurance included under K.S.A. 40-2123, and amendments thereto, and in addition thereto, the specific authority and duty to:

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

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

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

(4) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. During the first two years of operation of the plan, rates shall be established in an amount that is estimated by the board to cover all claims that may be made against the plan and the expenses of operating the plan. In following years, rates for coverage shall be reasonable in terms of the benefits provided, the risk experience and expenses of providing the coverage, except that such rates shall not exceed 150% of the average premium rate charged for similar coverage in the private market. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex and geographic location in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices, however particular health conditions or illnesses shall not constitute appropriate risk factors;

(5) assess members of the association in accordance with the provisions of K.S.A. 40-2121, and amendments thereto;

(6) **design the policies of insurance to be offered by the plan which shall cover at least the expenses enumerated in subsection (b) of K.S.A. 40-2123, and amendments thereto, but with such limitations and optional benefit levels as the plan prescribes**;

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

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

(d) The association shall administer a reinsurance program for medicare supplement policies issued to Kansas residents who are eligible for medicare by reason of disability. All medicare supplement insurers issuing or renewing medicare supplement policies in this state shall be participants in such reinsurance program. (1) On or before May 1, 2000, and each year thereafter, each issuer of a medicare supplement policy in the state shall provide to the association a calendar year accounting of the medicare supplement policies delivered or issued for delivery in the state and covering persons eligible for medicare by reason of disability who are under age 65. (2) The accounting for medicare supplement policies covering persons eligible by reason of disability and under age 65 shall include the total number of such persons covered, the total premium earned on such persons, and the total claims expense incurred with respect to such persons during such year as paid through March 31, without estimates for incurred but not reported claims. (3) The association shall use such reports to develop the assessment required under subsection (d) of K.S.A. 1999 Supp. 40-2121, and amendments thereto.

**History:** L. 1992, ch. 209, § 3; L. 1996, ch. 98, § 1; **L. 1997, ch. 190, § 8**; L. 1999, ch. 106, § 2; July 1.

# 40-2120

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2120. Same; plan administering carrier, selection, functions.** (a) The board shall select an insurer or third-party administrator to administer the plan. The board shall evaluate bids submitted by interested parties based on criteria established by the board which shall include:
(1) The bidder's proven ability to handle individual accident and health insurance;
(2) the efficiency of the bidder's claim paying procedure;
(3) an estimate of total charges for administering the plan; and
(4) the bidder's ability to administer the plan in a cost efficient manner.
(b) The administering carrier so selected shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service, the board shall invite all interested parties, including the current administering carrier, to submit bids to serve as the administering carrier for the succeeding three-year period. Selection of the administering carrier for the succeeding period shall be made at least six months prior to the end of the current three-year period. The administering carrier shall be paid as provided in the plan of operation.
(c) The administering carrier shall perform all administrative, eligibility and administrative claims payment functions relating to the plan, including:
(1) Establishing a billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;
(2) performing all necessary functions to assure timely payment of benefits to covered persons under the plan including making available information relating to the proper manner of submitting a claim for benefits to the plan, distributing forms upon which submission shall be made and evaluating the eligibility of each claim for payment under the plan;
(3) accepting payments of premiums from insured persons and transmitting such payments to the state treasurer for credit to the uninsurable health insurance plan fund established in K.S.A. 40-2126;
(4) submitting regular reports to the board regarding the operation of the plan. The frequency, content and form of the reports shall be as determined by the board;
(5) determining net written and earned premiums, the expense of administration, and the paid and incurred losses for each year and reporting such information to the board and the commissioner in a form and manner prescribed by the commissioner.
**History:** L. 1992, ch. 209, § 4; July 1.

# 40-2121

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

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

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

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

**For the tax year commencing after December 31, 1998, 65% of any assessment made against a member of the association pursuant to subsection (a) of this**

**section may be claimed by such member as a credit against such member's premium tax liability imposed by K.S.A. 12-2624, 40-252 or 40-3213 and amendments thereto, for the taxable year in which such assessment is paid.**

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

**The amendments made to the Kansas uninsurable health insurance plan act by chapter 190 of the 1997 Session Laws of Kansas shall expire on January 1, 2001.**

(d) In addition to the assessments otherwise authorized herein, the board shall assess all issuers of medicare supplement policies covering persons within this state to the extent necessary to assure that the excess losses, if any, are distributed among such issuers of medicare supplement policies in a ratio equal to the percentage market share in Kansas of each such issuer for medicare supplement policies covering persons eligible for medicare by reason of age. The association shall also assess to such issuers of medicare supplement policies the costs the association incurs in operating the reinsurance program, making assessments, and collecting and distributing moneys, which shall be assessed pro rata to such issuers based on the market share of such issuers of medicare supplement policies covering persons eligible for medicare by reason of age. Such assessment shall occur not later than July 1 of each year, based on such excess losses and such market shares for the immediately preceding calendar year. Issuers of medicare supplement policies shall remit the amount so assessed to the association within the time frames established by the board for payment of assessment otherwise authorized herein. The association shall pay to any issuer of medicare supplement policies entitled thereto such amount as is necessary to result in the equalization among all issuers of medicare supplement policies in Kansas of excess losses in a proportion equivalent to the percentage market share in Kansas of each issuer of medicare supplement policies covering persons eligible for medicare by reason of age. The amount of such assessments received by an insurer shall not be accounted for as premium income nor shall such amounts be subject to premium tax. The amount of such assessments shall not be available for use in premium tax credits provided for under subsection (c) of K.S.A. 1999 Supp. 40-2122, and amendments thereto. The association shall have the ability to enforce assessments through its board.

**History:** L. 1992, ch. 209, § 5; L. 1996, ch. 98, § 2; **L. 1997, ch. 190, § 9**; L. 1999, ch. 106, § 3; July 1.

# 40-2122

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2122. Same; persons eligible for plan coverage; termination upon cessation of eligibility; notice of availability of coverage.** (a) The following individuals shall be eligible for plan coverage provided they meet the criteria set forth in subsection (b):

(1) Any person who has been a resident of this state for at least six months;

(2) any person who is a legal domiciliary of this state who previously was covered under the high risk pool of another state, provided they apply for coverage under the plan within 63 days of losing such other coverage for reasons other than fraud or nonpayment of premiums; or

**(3) any federally defined eligible individual who is a legal domiciliary of this state.**

(b) Those individuals who are eligible for plan coverage under subsection (a) must 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 is in excess of the plan rate;

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

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

**(c) Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.**

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

(1) Any person who is eligible for medicare or is eligible for 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.

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

(f) 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.

**History:** L. 1992, ch. 209, § 6; L. 1995, ch. 129, § 1; **L. 1997, ch. 190, § 10**; L. 1998, ch. 174, § 4; L. 1999, ch. 30, § 1; July 1.

# 40-2123

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2123. Same; expenses and services covered under plan; exclusions; plan not subject to coverages mandated by other laws.** (a) The plan shall offer coverage to every eligible person pursuant to which such person's covered expenses shall be indemnified or reimbursed subject to the provisions of K.S.A. 40-2124 and amendments thereto.

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

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

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

(3) services of licensed dentists when such procedures would otherwise be performed by persons licensed to practice medicine and surgery;

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

(5) medically necessary diagnostic laboratory and x-ray services;

(6) drugs and controlled substances prescribed by a practitioner, as defined in subsection (x) of K.S.A. 65-1626 and amendments thereto, or drugs and controlled substances prescribed by a mid-level practitioner as defined in subsection (ii) of K.S.A. 65-1626 and amendments thereto. Coverage for outpatient prescriptions shall be subject to a mandatory 50% coinsurance provision, and coverage for prescriptions administered to inpatients shall be subject to a coinsurance provision as established in the plan; and

(7) subject to the approval of the commissioner, the board shall also review and recommend the inclusion of coverage for mental health services and such other primary and preventive health care services as the board determines would not materially impair affordability of the plan.

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

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

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

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

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

(i) Medicare or state law or programs;

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

(iii) military service-connected disability benefits;

(iv) other benefit or entitlement programs provided for by the laws of the United States (except title XIX of the social security act of 1965);

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

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

(B) This exclusion shall not apply to services or charges which exceed the benefits payable

under the applicable programs listed above and which are otherwise eligible for payment under this section.
(5) Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering such service;
(6) that part of any charge for services or articles rendered or prescribed which exceeds the rate established by K.S.A. 40-2131 and amendments thereto for such services;
(7) services or articles not medically necessary;
(8) care which is primarily custodial or domiciliary in nature;
(9) cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;
(10) eye surgery if corrective lenses would alleviate the problem;
(11) experimental services or supplies not generally recognized as the normal mode of treatment for the illness or injury involved;
(12) service of a blood donor and any fee for failure of the insured to replace the first three pints of blood provided in each calendar year; and
(13) personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.
(d) Except as expressly provided for in this act, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to the plan.
(e) A plan may incorporate provisions that will direct covered persons to the most appropriate lowest cost health care provider available.
**History:** L. 1992, ch. 209, § 7; L. 1993, ch. 132, § 5; L. 1997, ch. 184, § 1; L. 1999, ch. 115, § 6; Apr. 1, 2000.

# 40-2124

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2124. Uninsurable health insurance plan; deductible and copayment provisions; maximum lifetime benefit; preexisting conditions exclusion; reduction of plan benefits for duplicate coverage; recovery of benefits paid for noncovered expenses.** (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. **On and after January 1, 1998, the plan shall offer to current participants and new enrollees no fewer than four choices of deductible and copayment options.** 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 $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.

**History:** L. 1992, ch. 209, § 8; L. 1994, ch. 125, § 1; **L. 1997, ch. 190, § 11**; July 1.

# 40-2125

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2125. Same; loans to finance plan commencement, repayment.** Upon request of the commissioner to provide for amounts that may be required to assist in financing the commencement of operations of the plan, the pooled money investment board shall loan to the uninsurable health insurance plan fund not to exceed $500,000 on July 15, 1992, July 15, 1993, July 15, 1994, and July 15, 1995. The total of the amounts so loaned shall be repaid from the uninsurable health insurance plan fund over the period of 10 fiscal years after fiscal year 1994 in accordance with appropriation acts. Amounts loaned under this section shall not bear interest.

**History:** L. 1992, ch. 209, § 9; July 1.

# 40-2126

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2126. Same; uninsurable health insurance plan fund; transfers to fund plan losses; transfer of plan surplus to fund.** There is hereby created in the state treasury a fund to be known and designated as the uninsurable health insurance plan fund. Periodically, the plan shall compare the premiums earned to the losses and expenses sustained by the plan. If there is any excess of losses and expenses over premiums earned, an amount determined by the commissioner to be necessary to fund such excess losses and expenses shall be transferred from the uninsurable health insurance plan fund to the plan to pay claims and expenses resulting from its operation. If there is any surplus of premiums earned over losses and expenses, such surplus shall be transferred to the uninsurable health insurance plan fund from the plan. All expenditures from the uninsurable health insurance plan fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the commissioner or a person or persons designated by the commissioner.
**History:** L. 1992, ch. 209, § 10; July 1.

# 40-2127

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2127. Same; annual financial report to commissioner; financial examination by commissioner.** (a) Not later than July 1, 1993, and July 1 of each succeeding year, the board shall submit an audited financial report for the plan for the preceding calendar year to the commissioner in a form provided or prescribed by the commissioner.
(b) The financial status of the plan shall be subject to examination by the commissioner or the commissioner's designee. Such examination shall be conducted at least once every three years beginning January 1, 1995. The commissioner shall transmit a copy of the results of such examination to the legislature by February 1 of the year following the year in which the examination is conducted.
**History:** L. 1992, ch. 209, § 11; July 1.

# 40-2128

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2128. Same; submission of financial report to joint committee on health care decisions for the 90's; information required.** The commissioner shall submit annually to the joint committee on health care decisions for the 90's the financial report of the plan, the number of individuals covered and the specific coverage of the plan. The report shall compare the provider reimbursement rates to those of medicaid and medicare, and include the number of participating providers and their locations and other information as the joint committee shall request.
**History:** L. 1992, ch. 209, § 12; July 1.

# 40-2129

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2129. Same; commissioner's recommendations for plan improvements to joint committee, when.** If, by July 1, 1995, operation of the Kansas uninsurable health insurance plan has inadequate participation; or activity in the health insurance marketplace materially impairs affordability or marketability of the plan; or the commissioner deems other factors jeopardize the operation of the plan, the commissioner shall develop and submit to the joint committee on health care decisions for the 90's recommendations the commissioner deems necessary to ensure the successful operation of the plan.
**History:** L. 1992, ch. 209, § 13; July 1.

# 40-2130

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2130. Same; form directing withholding or withdrawal of life-sustaining procedures to be provided applicants for coverage; retention upon execution.** The association or a member insurer thereof shall provide every applicant for health coverage under the provisions of this act with a form for making a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition in substantial conformance with subsection (c) of K.S.A. 65-28,103, and amendments thereto. If such applicant elects to execute such declaration the applicant shall submit a copy of such declaration to the association or member insurer thereof, and such copy shall be retained and made a part of the applicant's permanent records.
**History:** L. 1992, ch. 209, § 14; July 1.

# 40-2131

**Chapter 40.--INSURANCE**
**Article 21.--MISCELLANEOUSPROVISIONS**

**40-2131. Same; health service provider agreements; charge to insured not permitted, when.** Unless otherwise specified by the plan, as a prerequisite for payment from the plan, each provider of health services to persons covered under the plan shall enter into a provider agreement with the association under which reimbursement for services provided shall be at rates established by the board. Providers shall not charge persons covered under the plan with the exception of authorized deductible and co-pay requirements and noncovered services if the recipient has been informed in advance of the noncoverage.

**History:** L. 1992, ch. 209, § 15; July 1.

**Kathleen Sebelius**
Commissioner of Insurance
**Kansas Insurance Department**

TO: Senate Committee on Financial Institutions and Insurance

FROM: Linda J. De Coursey, Director of Government Affairs

RE: S.B. 440 (Risk Based Capital)

DATE: January 24, 2000

I am appearing in support of Senate Bill 440, which was introduced at the request of the Kansas Department of Insurance. This bill makes a change to the law dealing with the filing of financial reports by insurance companies with the Department.

Risk based capital ("RBC") is the method used by the Department to evaluate the financial solvency of insurance carriers doing business in this state. Companies must file financial reports with the Department using RBC instructions and formulas developed by the National Association of Insurance Commissioners ("NAIC"). These instructions are amended each year by the NAIC to reflect changes in accounting procedures.

Our current law (K.S.A. 1999 Supp. 40-2c01) requires companies to use the 1998 version of the RBC instructions. The bill would reflect a change in the date of the standard so that carriers use the RBC formulas in effect as of December 31, 1999.

The bill also strikes the language "and adopted as rules and regulations by the Commissioner." The Insurance Department has not adopted the RBC formulas as rules and regulations in the past, and does not think there is a need to do that, if in fact, we come before you every year and insert the new date. We do not think that by merely defining where the RBC instructions come from in any way defers Kansas law to the National Association of Insurance Commissioners (NAIC). Insurance Department staff indicates that no company or individual has ever requested from the Insurance Department a copy of these instructions, and that to adopt them even by reference just isn't necessary, and even duplicative.

I respectfully ask that this committee approve S.B. 440 favorable for passage.

Senate Financial Institutions & Insurance
Date 1/31/00
Attachment # 2

420 SW 9th Street
Topeka, Kansas 66612-1678

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# KANSAS INSURANCE ASSOCIATIONS

David A. Hanson, Legislative Counsel
900 Mercantile Bank Tower
800 S.W. Jackson
Topeka, Kansas 66612-1259

PHONE 785-232-0545
FAX 785-232-0005

**Senate Financial Institutions and Insurance Committee**
**Testimony on Senate Bill 440**
**Presented by David A. Hanson**
**on behalf of**
**Kansas Insurance Associations**
**January 24, 2000**

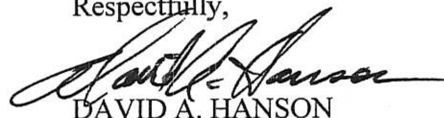
Mr. Chairman and Members of the Committee:

Thank you for this opportunity to present information on behalf of the Kansas Association of Property and Casualty Insurance Companies and the Kansas Life Insurance Association, whose members are domestic insurance companies in Kansas.

The risk based capital provisions referenced in Senate Bill 440 were developed by the NAIC for adoption and use by the states as a standardized method of monitoring the solvency of insurers and the need for corrective action. We had requested the reference date in the statutory definition of "RBC instructions" to make sure that the adopted instructions and formula were limited to those that we had had an opportunity to review, rather than potential future revisions, which could adversely affect our companies' risk-based capital and the resulting action or control levels. While we believe our companies' remain in good standing under the previously adopted NAIC instructions and formula, we also believe any significant changes in those instructions and formula by the NAIC should be carefully considered before adopting them in Kansas.

Our companies have been reviewing the proposed changes and we do not believe there will be any substantial adverse effect from the revisions proposed in Senate Bill 440. Thank you for your consideration.

Respectfully,



DAVID A. HANSON

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**Kansas Association of Property & Casualty Insurance Cos.**

Member Companies:

Armed Forces Insurance Exchange
Ft. Leavenworth

Bremen Farmers Mutual Ins. Co.
Bremen

Columbia Insurance Group
Salina

Farm Bureau Mutual Ins. Co.
Manhattan

Farmers Alliance Mutual Ins. Co.
McPherson

Farmers Mutual Ins. Co.
Ellinwood

Kansas Mutual Ins. Co.
Topeka

Marysville Mutual Ins. Co.
Marysville

Mutual Aid Assn. of the Church of the Brethren
Abilene

Upland Mutual Ins., Inc.
Chapman

**Kansas Life Insurance Association**

Member Companies:

The American Home Life Ins. Co.
Topeka

American Investors Life Ins. Co.
Topeka

Blue Cross & Blue Shield of Kansas
Topeka

Employers Reinsurance Corp.
Overland Park

First Life America Corporation
Topeka

Kansas Farm Bureau Life Ins. Co.
Manhattan

The Pyramid Life Insurance Co.
Shawnee Mission

Security Benefit Life Ins. Co.
Topeka

Senate Financial Institutions & Insurance
Date 1/31/00
Attachment # 3