

CHAPTER 136
HOUSE BILL No. 2214

AN ACT relating to insurance; concerning the regulation thereof; amending K.S.A. 16-1803 and K.S.A. 2008 Supp. 40-2,105, 40-2,105a, 40-2209, 40-2258 and 40-3209 and repealing the existing sections.

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

New Section 1. The provisions of sections 1 through 5, and amendments thereto, shall be known and may be cited as the controlled insurance programs act.

New Sec. 2. As used in the controlled insurance programs act:

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

(b) "Completed operations liability" has the meaning ascribed thereto in K.S.A. 40-4101, and amendments thereto.

(c) The terms "construction," "contract," "contractor," "owner," "person" and "subcontractor" have the meanings ascribed thereto in K.S.A. 16-1802, and amendments thereto.

(d) "Controlled insurance program" means a program of liability or workers compensation insurance coverage, or both, that is established by an owner or contractor who contractually requires participation by contractors or subcontractors who are engaged in work required by a construction contract. Controlled insurance programs shall include, but not be limited to, coverage programs that are for a fixed term of coverage on a single construction site or project or multiple projects, and a consolidated or wrap-up insurance program as the term is used in subsection (b)(3) of K.S.A. 16-1803, and amendments thereto. A controlled insurance program subject to this act shall not include surety or builders risk.

(e) "Participant" means any contractor or subcontractor whose participation in a controlled insurance program is required by a construction contract.

(f) "Sponsoring participant" means the owner or contractor who establishes the controlled insurance program.

(g) "Substantial completion" shall have the meaning ascribed to it in K.S.A. 16-1902 and amendments thereto.

New Sec. 3. The commissioner by rules and regulations, shall require that:

(a) Controlled insurance programs shall:

(1) Establish a method for quarterly reporting of the participant's respective claims details and loss information to that participant;

(2) provide that cancellation of any or all of the coverage provided to a participant prior to completion of work on the applicable project, shall require the owner or contractor who establishes a controlled insurance program to either replace the insurance or pay the subcontractor's cost to do so;

(3) not charge enrolled participants who are not the sponsoring participants, a deductible in excess of \$2,500 per occurrence or a per claim assessment by the sponsor;

(4) keep self-insured retentions fully funded or collateralized by the owner or contractor establishing the controlled insurance program. This paragraph shall not apply to deductible programs;

(5) disclose specific requirements for safety or equipment prior to accepting bids from contractors and subcontractors on a construction project; and

(6) allow monetary fines for alleged safety violations to be assessed only by government agencies.

(b) If a controlled insurance program includes general liability coverage for the participants, then:

(1) Coverage for completed operations liability shall not, after substantial completion of a construction project, be canceled, lapse or expire before the limitation on actions has expired as established by subsection (b) of K.S.A. 60-513, and amendments thereto, but in no case greater than 10 years, and if another carrier takes responsibility for completed operations liability coverage, any and all prior completed operation liability carriers will be released from completed operations liability unless specified otherwise in subsequent policies;

(2) general liability coverage shall not be required of project participants except for liabilities not arising on the site or sites of the construc-

tion project. Any coverage maintained by the participants shall cover liabilities not arising on the site or sites of the construction project;

(3) the general liability coverage provided to participants shall provide for severability of interest, except with respect to limits of liability, so that participants shall be treated as if separately covered under the policy;

(4) participants shall be given the same shared limits of liability coverage as applies to the sponsoring participant under the controlled insurance program; and

(5) participants shall not be required to waive rights of recovery for claims covered by the controlled insurance program against another participant in the controlled insurance program covered by general liability insurance provided by the controlled insurance program.

(c) If a controlled insurance program includes coverage for the workers compensation liabilities of the participants, then:

(1) Workers compensation coverage shall include all workers compensation for which payroll attributable to the contractual agreement has been reported and the premiums collected covering all services performed incidental to, arising out of or emanating from the construction site or sites and the coming or going to or from the site or sites; and

(2) participants shall not be required to provide employment to a worker who has been injured on the job unless:

(A) The worker's treating health care provider certifies that the worker is fit to perform the participant's work on the job site consistent with the treating physician's limitations; and

(B) the employer has the pre-injury job or modified work available.

Nothing in this subsection or any rules and regulations adopted pursuant to the controlled insurance program act shall affect any rights, remedies or duties under the workers compensation act or any other state or federal employment law.

New Sec. 4. In addition to such other rules and regulations adopted pursuant to this act, the commissioner is hereby authorized to adopt such rules and regulations relating to controlled insurance programs as may be necessary to carry out the provisions of the controlled insurance programs act.

New Sec. 5. The commissioner shall adopt all rules and regulations required by this act by January 1, 2010.

Sec. 6. K.S.A. 16-1803 is hereby amended to read as follows: 16-1803. (a) Subject to the provisions of subsections (b), (c), (d), (e), (f), (g) and (h) and K.S.A. 16-1804 and 16-1805, and amendments thereto, all persons who enter into a contract for private construction after the effective date of this act, shall make all payments pursuant to the terms of the contract.

(b) The following provisions in a contract for private construction shall be against public policy and shall be void and unenforceable:

(1) A provision that purports to waive, release or extinguish the right to resolve disputes through litigation in court or substantive or procedural rights in connection with such litigation except that a contract may require binding arbitration as a substitute for litigation or require non-binding alternative dispute resolution as a prerequisite to litigation;

(2) a provision that purports to waive, release or extinguish rights provided by article 11 of chapter 60 of the Kansas Statutes Annotated, and amendments thereto, except that a contract may require a contractor or subcontractor to provide a waiver or release of such rights as a condition for payment, but only to the extent of the amount of payment received; and

(3) a provision that purports to waive, release or extinguish rights of subrogation for losses or claims covered or paid by liability or workers compensation insurance except that a contract may require waiver of subrogation for losses or claims paid by a consolidated or wrap-up insurance program, owners and contractors protective liability insurance, or project management protective liability insurance, *unless otherwise prohibited under subsection (b)(5) of section 3, and amendments thereto.*

(c) Any provision in a contract for private construction providing that a payment from a contractor or subcontractor to a subcontractor is contingent or conditioned upon receipt of a payment from any other private party, including a private owner, is no defense to a claim to enforce a mechanic's lien or bond to secure payment of claims pursuant to the provisions of article 11 of chapter 60 of the Kansas Statutes Annotated,

and amendments thereto.

(d) All contracts for private construction shall provide that payment of amounts due a contractor from an owner, except retainage, shall be made within 30 days after the owner receives a timely, properly completed, undisputed request for payment.

(e) If the owner fails to pay a contractor within 30 days following receipt of a timely, properly completed, undisputed request for payment, the owner shall pay interest to the contractor beginning on the thirty-first day after receipt of the request for payment, computed at the rate of 18% per annum on the undisputed amount.

(f) A contractor shall pay its subcontractors any amounts due within seven business days of receipt of payment from the owner, including payment of retainage, if retainage is released by the owner, if the subcontractor has provided a timely, properly completed and undisputed request for payment to the contractor.

(g) If the contractor fails to pay a subcontractor within seven business days, the contractor shall pay interest to the subcontractor beginning on the eighth business day after receipt of payment by the contractor, computed at the rate of 18% per annum on the undisputed amount.

(h) The provisions of subsections (f) and (g) shall apply to all payments from subcontractors to their subcontractors.

Sec. 7. K.S.A. 2008 Supp. 40-2,105 is hereby amended to read as follows: 40-2,105. (a) On or after the effective date of this act, every insurer which issues any individual *policy of accident and sickness insurance* or group policy of accident and sickness insurance ~~providing to a small employer as defined in K.S.A. 40-2209d, and amendments thereto, which provides~~ medical, surgical or hospital expense coverage for other than specific diseases or accidents only and which provides for reimbursement or indemnity for services rendered to a person covered by such policy in a medical care facility, must provide for reimbursement or indemnity under such individual policy or under such *small employer* group policy, except as provided in subsection (d), which shall be limited to not less than ~~30~~ 45 days per year ~~when such person is confined for treatment of alcoholism, drug abuse or nervous or mental conditions for in-patient treatment of mental illness~~ in a medical care facility licensed under the provisions of K.S.A. 65-429, and amendments thereto, ~~and not less than 30 days per year when such person is confined for treatment of alcoholism, drug abuse or substance use disorders~~ in a treatment facility for alcoholics licensed under the provisions of K.S.A. 65-4014, and amendments thereto, a treatment facility for drug abusers licensed under the provisions of K.S.A. 65-4605, and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, or a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b, and amendments thereto. Such individual policy or such *small employer* group policy shall also provide for reimbursement or indemnity, except as provided in subsection (d), of the costs of treatment of such person for *mental illness*, alcoholism, drug abuse and ~~nervous or mental conditions~~ *substance use disorders subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses and treatment limitations as apply to other covered services*, limited to not less than 100% of the first \$100, 80% of the next \$100 and 50% of the next \$1,640 in any year and limited to not less than ~~\$7,500~~ \$15,000 in such person's lifetime, *with no annual limits*, in the facilities enumerated when ~~confinement in-patient treatment~~ is not necessary for the treatment or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas.

(b) For the purposes of this section "~~nervous or mental conditions~~" "*mental illness, alcoholism, drug abuse or substance use*" means disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association ~~but shall not include conditions:~~

~~—(1) Not attributable to a mental disorder that are a focus of attention or treatment (DSM-IV, 1994); and~~

~~—(2) defined as a mental illness in K.S.A. 2008 Supp. 40-2,105a and amendments thereto.~~

(c) The provisions of this section shall be applicable to health maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

(d) There shall be no coverage under the provisions of this section

for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008, and amendments thereto, or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.

(e) The provisions of this section shall not apply to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.

~~(f) The provisions of this section shall be applicable to the Kansas state employees health care benefits program developed and provided by the Kansas state employees health care commission.~~

~~(g) The outpatient coverage provisions of this section shall not apply to a high deductible health plan as defined in federal law if such plan is purchased in connection with a medical or health savings account pursuant to that federal law, regardless of the effective date of the insurance policy. After the amount of eligible deductible expenses have been paid by the insured, the outpatient costs of treatment of the insured for alcoholism, drug abuse and nervous or mental conditions shall be paid on the same level they are provided for a medical condition, subject to the yearly and lifetime maximums provided in subsection (a).~~

~~(f) Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.~~

~~(g) Utilization review for mental illness shall be consistent with provisions in K.S.A. 40-22a01 through 40-22a12, and amendments thereto.~~

Sec. 8. K.S.A. 2008 Supp. 40-2,105a is hereby amended to read as follows: 40-2,105a. (a) (1) Any group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides *medical, surgical or hospital expense* coverage for mental health benefits and which is delivered, issued for delivery, amended or renewed on or after January 1, 2002, shall include, coverage for diagnosis and treatment of mental illnesses. ~~Except as provided in paragraph (2), and alcoholism, drug abuse or other substance use disorders. Reimbursement or indemnity shall be provided for treatment in a medical care facility licensed under the provisions of K.S.A. 65-429, and amendments thereto, treatment facilities licensed under K.S.A. 65-4605, and amendments thereto, a community mental health center or clinic licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, a psychiatric hospital licensed under the provisions of K.S.A. 75-3307b, and amendments thereto, or by a physician or psychologist licensed to practice under the laws of the state of Kansas.~~ Such coverage shall be subject to the same deductibles, copayments, coinsurance, out-of-pocket expenses, treatment limitations and other limitations as apply to other covered services.

~~(2) The coverage required by paragraph (1) shall include annual coverage for both 45 days of in-patient care for mental illness and for 45 visits for out-patient care for mental illness shall include treatment for in-patient care and out-patient care for mental illness, alcoholism, drug abuse or substance use disorders.~~

(b) Notwithstanding the provisions of K.S.A. 40-2240a, and amendments thereto, the state insurance department shall deliver to the president of the senate and to the speaker of the house of representatives on or before January 1, 2003, a report indicating the impact of providing mental illness benefits required by this act. Such report shall include information regarding access to and usage of such services and the cost of such services.

~~(c) For the purposes of this section, "mental illness, alcoholism, drug abuse or substance use" means the following: Schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, paranoid or delusional disorder, atypical psychosis, major affective disorders (bipolar and major depression), cyclothymic and dysthymic disorders, obsessive compulsive disorder, panic disorder, pervasive developmental disorder, including autism, attention deficit disorder and attention deficit hyperactive any disorder as such terms are defined in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association but shall not include conditions not attributable to a mental disorder that are a focus of attention or treatment.~~

~~(d) (c) The provisions of this section shall be applicable to health~~

maintenance organizations organized under article 32 of chapter 40 of the Kansas Statutes Annotated.

~~(e)~~ (d) The provisions of this section shall not apply to any *small employer group policy, as defined under K.S.A. 40-2209, and amendments thereto, providing medical, surgical or hospital expense coverage or to any medicare supplement policy of insurance, as defined by the commissioner of insurance by rule and regulation.*

~~(f)~~ (e) The provisions of this section shall be applicable to the Kansas state employees health care benefits program and municipal funded pools.

~~(g)~~ (f) The provisions of this section shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-2227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, any coverage issued as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

~~(h) From and after January 1, 2002, the provisions of K.S.A. 40-2-105, and amendments thereto, shall not apply to mental illnesses as defined in this act.~~

~~(i) There shall be no coverage under this section for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.~~

(g) *Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.*

(h) *There shall be no coverage under the provisions of this section for any assessment against any person required by a diversion agreement or by order of a court to attend an alcohol and drug safety action program certified pursuant to K.S.A. 8-1008, and amendments thereto, or for evaluations and diagnostic tests ordered or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.*

(i) *Utilization review for mental illness shall be consistent with provisions in K.S.A. 40-22a01 through 40-22a12, and amendments thereto.*

Sec. 9. On and after November 1, 2009, K.S.A. 2008 Supp. 40-2258 is hereby amended to read as follows: 40-2258. (a) An accident and sickness insurer which offers coverage through a group policy or *certificate of coverage* providing hospital, medical or surgical expense benefits pursuant to K.S.A. 40-2209, and amendments thereto, which includes mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits shall be subject to the following requirements:

(1) If the policy does not include an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits, the policy may not impose any aggregate lifetime limit on mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits;

(2) if the policy includes an aggregate lifetime limit on substantially all hospital, medical and surgical expense benefits the plan shall either: (A) Apply the applicable lifetime limit both to the hospital, medical and surgical expense benefits to which it otherwise would apply and to mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits and not distinguished in the application of such limit between such hospital, medical and surgical expense benefits and mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits; or (B) not include any aggregate lifetime limit on mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits that is less than the applicable lifetime limit on hospital, medical and surgical expense benefits;

(3) if the policy does not include an annual limit on substantially all hospital, medical and surgical expense benefits, the plan or coverage may not impose any annual limit on mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits; and

(4) if the policy includes an annual limit on substantially all hospital, medical and surgical expense benefits the policy shall either: (A) Apply the applicable annual limit both to hospital, medical and surgical expense benefits to which it otherwise would apply and to mental ~~health~~ *illness or*

alcoholism, drug abuse or other substance use disorder benefits and not distinguish in the application of such limit between such hospital, medical and surgical expense benefits and mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits; or (B) not include any annual limit on mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits that is less than the applicable annual limit.

(b) If the group policy providing hospital, medical or surgical expense benefits is not otherwise covered by subsection (a) and either does not apply a lifetime or annual benefit or applies different lifetime or annual benefits to different categories of hospital, medical and surgical expense benefits, the commissioner may adopt rules and regulations under which subsections (a)(2) and (a)(4) are applied to such policies with respect to mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits by substituting for the applicable lifetime or annual limits an average limit that is computed taking into account the weighted average of the lifetime or annual limits applicable to such categories.

(c) Nothing in this section shall be construed as either:

(1) Requiring an accident and sickness policy to offer mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits except as otherwise required by K.S.A. ~~40-2,105~~ *40-2,105a*, and amendments thereto; or

(2) affecting any terms and conditions of a policy which does include mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits including provisions regarding cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requirements relating to the amount, duration or scope of mental ~~health~~ *illness or alcoholism, drug abuse or other substance use disorder* benefits under the plan or coverage, except as specifically provided in subsection (a).

(d) This section shall not apply to any group accident and health insurance policy which is sold to a small employer as defined in K.S.A. 40-2209, and amendments thereto.

(e) This section shall not apply with respect to a group policy providing hospital, medical or surgical expense benefits if the application of this section will result in an increase in the cost under the plan of at least ~~1%~~ *2% in the case of the first plan year in which this section is applied and 1% in the case of each subsequent plan year. Determinations as to increases in actual costs under a plan shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American academy of actuaries. All such determinations shall be in a written report prepared by the actuary.*

(f) In the case of a group policy providing hospital, medical or surgical expense benefits that offers an eligible employee, member or dependent two or more benefit package options under the policy, subsections (a) and (b) shall be applied separately with respect to each such option.

(g) As used in this section:

(1) “Aggregate lifetime limit” means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount that may be paid with respect to such benefits under the policy with respect to an eligible employee, member or dependent;

(2) “annual limit” means, with respect to benefits under a group policy providing hospital, medical or surgical expense benefits, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the policy with respect to an eligible employee, member or dependent;

(3) “hospital, medical or surgical expense benefits” means benefits with respect to hospital, medical or surgical services, as defined under the terms of the policy, ~~but does not include mental health benefits;~~

(4) “mental ~~health~~ *illness* benefits” means benefits with respect to mental health services, as defined under the terms of the policy, ~~but does not include benefits with respect to treatment of substance abuse or chemical dependency;~~

(5) “*alcoholism, drug abuse or substance use disorder benefits*” means benefits with respect to services for the treatment of alcoholism, drug abuse or other substance use disorders, as defined under the terms of the policy;

(6) “*mental illness, alcoholism, drug abuse or substance use*” means

disorders specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American psychiatric association.

(h) This section shall be effective for group policies providing hospital, medical or surgical expense benefits which are entered into or renewed after January 1, 1998. ~~This section shall not apply to benefits for services furnished on or after December 31, 2008.~~

(i) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

Sec. 10. K.S.A. 2008 Supp. 40-2209 is hereby amended to read as follows: 40-2209. (a) (1) Group sickness and accident insurance is declared to be that form of sickness and accident insurance covering groups of persons, with or without one or more members of their families or one or more dependents. Except at the option of the employee or member and except employees or members enrolling in a group policy after the close of an open enrollment opportunity, no individual employee or member of an insured group and no individual dependent or family member may be excluded from eligibility or coverage under a policy providing hospital, medical or surgical expense benefits both with respect to policies issued or renewed within this state and with respect to policies issued or renewed outside this state covering persons residing in this state. For purposes of this section, an open enrollment opportunity shall be deemed to be a period no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

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

(A) The individual:

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

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

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

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

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

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

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

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

(4) (A) No group policy providing hospital, medical or surgical expense benefits issued or renewed within this state or issued or renewed outside this state covering residents within this state shall limit or exclude benefits for specific conditions existing at or prior to the effective date of coverage thereunder. Such policy may impose a preexisting conditions exclusion, not to exceed 90 days following the date of enrollment for benefits for conditions whether mental or physical, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received in the 90 days prior to the effective date of enrollment. Any preexisting conditions exclusion shall run concurrently with any waiting period.

(B) Such policy may impose a waiting period after full-time employment starts before an employee is first eligible to enroll in any applicable group policy.

(C) A health maintenance organization which offers such policy which does not impose any preexisting conditions exclusion may impose an affiliation period for such coverage, provided that: (i) such application period is applied uniformly without regard to any health status related factors and (ii) such affiliation period does not exceed two months. The affiliation period shall run concurrently with any waiting period under the plan.

(D) A health maintenance organization may use alternative methods from those described in this subsection to address adverse selection if approved by the commissioner.

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

(F) For the purposes of this section, the term "date of enrollment" means the date the individual is enrolled under the group policy or, if earlier, the first day of the waiting period for such enrollment.

(G) For the purposes of this section, the term "waiting period" means with respect to a group policy the period which must pass before the individual is eligible to be covered for benefits under the terms of the policy.

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

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

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

(8) Such policy shall waive such a preexisting conditions exclusion to the extent the employee or member or individual dependent or family member was covered by (A) a group or individual sickness and accident policy, (B) coverage under section 607(1) of the employees retirement income security act of 1974 (ERISA), (C) a group specified in K.S.A. 40-2222 and amendments thereto, (D) part A or part B of title XVIII of the social security act, (E) title XIX of the social security act, other than coverage consisting solely of benefits under section 1928, (F) a state children's health insurance program established pursuant to title XXI of the social security act, (G) chapter 55 of title 10 United States code, (H) a medical care program of the Indian health service or of a tribal organization, (I) the Kansas uninsurable health plan act pursuant to K.S.A. 40-

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

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

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

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

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

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

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

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

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

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

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

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

(3) In any case in which an accident and sickness insurer which offers a group policy providing hospital, medical or surgical expense benefits

decides to discontinue offering such type of group policy, such coverage may be discontinued only if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Under a policy issued to any other type of group which the commissioner of insurance may find is properly subject to the issuance of a group sickness and accident policy or contract.

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

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

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

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

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

become payable.

(i) A group policy of insurance delivered or issued for delivery or renewed which provides hospital, surgical or major medical expense insurance, or any combination of these coverages, on an expense incurred basis, shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination, shall be entitled to have such coverage nonetheless continued under the group policy for a period of 18 months and have issued to the employee or member or such employee's or member's covered dependents by the insurer, at the end of such eighteen-month period of continuation, a policy of health insurance which conforms to the applicable requirements specified in this subsection. This requirement shall not apply to a group policy which provides benefits for specific diseases or for accidental injuries only or a group policy issued to an employer subject to the continuation and conversion obligations set forth at title I, subtitle B, part 6 of the employee retirement income security act of 1974 or at title XXII of the public health service act, as each act was in effect on January 1, 1987 to the extent federal law provides the employee or member or such employee's or member's covered dependents with equal or greater continuation or conversion rights; or an employee or member or such employee's or member's covered dependents shall not be entitled to have such coverage continued or a converted policy issued to the employee or member or such employee's or member's covered dependents if termination of the insurance under the group policy occurred because:

(1) The employee or member or such employee's or member's covered dependents failed to pay any required contribution after receiving reasonable notice of such required contribution from the insurer in accordance with rules and regulations adopted by the commissioner of insurance; (2) any discontinued group coverage was replaced by similar group coverage within 31 days; (3) the employee or member is or could be covered by medicare (title XVIII of the United States social security act as added by the social security amendments of 1965 or as later amended or superseded); (4) the employee or member is or could be covered to the same extent by any other insured or lawful self-insured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

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

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph (20) of this subsection.

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

(3) The employer shall give the employee and such employee's covered dependents reasonable notice of the right to continuation of coverage. The terminated employee or member shall pay to the ~~employer~~ *insurance carrier* the premium for the eighteen-month continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group. Failure to pay such premium shall terminate coverage under the group policy at the end of the period for which the premium has been paid. The premium rate charged for converted policies issued subsequent to the period of continued coverage

shall be such that can be expected to produce an anticipated loss ratio of not less than 80% based upon conversion, morbidity and reasonable assumptions for expected trends in medical care costs. In the event the group policy is terminated and is not replaced, converted policies may be issued at self-sustaining rates that are not unreasonable in relation to the coverage provided based on conversion, morbidity and reasonable assumptions for expected trends in medical care costs. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

group policy from which conversion is made.

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

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

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

(i) The smaller of the following amounts:

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

(ii) The smaller of the following amounts:

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

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

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

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

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

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

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

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

ductible option between \$500 and \$1,000, and a third deductible option midway between the high and low deductible options.

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

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

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

(16) Subject to the conditions set forth above, the continuation and conversion privileges shall also be available:

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

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

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

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

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

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

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

(k) (1) No policy issued by an insurer to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

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

(l) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

Sec. 11. K.S.A. 2008 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of group and individual certificates of coverage and contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

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

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

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

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

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

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

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

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

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

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

(17) and (19) of subsection (j) of K.S.A. 40-2209, and amendments thereto;

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

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

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

(b) No health maintenance organization or medicare provider organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than co-payments and deductibles, to such provider in the event of nonpayment by the health maintenance organization or medicare provider organization for any services which have been performed under contracts between such enrollees and the health maintenance organization or medicare provider organization. Further, any contract between a health maintenance organization or medicare provider organization and a provider shall provide that if the health maintenance organization or medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or medicare provider organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. If there is no written contract between the health maintenance organization or medicare provider organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. Any action by a provider to collect or attempt to collect from a subscriber or enrollee any sum owed by the health maintenance organization to a provider shall be deemed to be an unconscionable act within the meaning of K.S.A. 50-627 and amendments thereto.

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

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

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

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

Sec. 12. K.S.A. 16-1803 and K.S.A. 2008 Supp. 40-2,105, 40-2,105a, 40-2209 and 40-3209 are hereby repealed.

Sec. 13. On and after November 1, 2009, K.S.A. 2008 Supp. 40-2258 is hereby repealed.

Sec. 14. This act shall take effect and be in force from and after its publication in the statute book.