

REPORTS OF STANDING COMMITTEES

MR. PRESIDENT:

The Committee on **Financial Institutions and Insurance** recommends **HB 2077** be amended on page 1, by striking all in lines 6 through 36;

By striking all on page 2 and inserting the following:

"Section 1. K.S.A. 2010 Supp. 40-2122 is hereby amended to read as follows: 40-2122. (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;

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

(4) any federally defined eligible individual for FTAA.

(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 is a child under the age of 19 years and has been unable to purchase or obtain coverage under an individual health insurance policy providing health insurance coverage, because such coverage is not available for sale in the county in which the child resides;

~~(3)~~ (4) such person has applied for health insurance and has been quoted a premium rate which is in excess of the plan rate;

~~(4)~~ (5) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition;

~~(5)~~ (6) such person is a federally defined eligible individual; or

~~(6)~~ (7) such person is a federally defined eligible individual for FTAA.

(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, including coverage under the consolidated omnibus budget reconciliation act (COBRA), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person:

(A) Is eligible for the credit for health care costs under section 35 of the internal revenue code of 1986; and

(B) has three months of prior creditable coverage as described in subsection (c) of K.S.A. 40-2124, and amendments thereto; 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.

Sec. 2. K.S.A. 2010 Supp. 40-2124 is hereby amended to read as follows: 40-2124. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. The plan 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 ~~\$2,000,000~~ \$3,000,000 per covered individual.

(c) 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 either 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 or an individual under the age of 19 years who is eligible for enrollment in the plan under paragraph (3) of subsection (b) of K.S.A. 40-2122, and amendments thereto. For any individual who is eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986, the preexisting conditions limitation will not apply whenever such individual has maintained creditable health insurance coverage for an aggregate period of three months, not counting any period prior to a 63-day break in coverage, as of the date on which such individual seeks to enroll in coverage provided by this act.

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

(2) The association shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this section.

Sec. 3 K.S.A. 2010 Supp. 40-2122 and 40-2124 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.";

On page 1, in the title, in line 1, by striking all following "concerning"; by striking all in lines 2 and 3 and inserting "the Kansas uninsurable health insurance plan act; pertaining to lifetime limits; pertaining to participation in plan by certain children; amending K.S.A. 2010 Supp. 40-2122 and 40-2124 and repealing the existing sections.";

And the bill be passed as amended.

Chairperson

