HOUSE BILL No. 2209

AN ACT concerning insurance; relating to life insurance unfair or deceptive acts or practices; third party administrator license and renewal application fees; purchase of cybersecurity insurance; association health plans; healthcare benefit coverage; establishing the unclaimed life insurance benefits act; amending K.S.A. 40-2209b and 40-2209e and K.S.A. 2018 Supp. 40-2209, 40-2209d, 40-2222, 40-2222, as amended by section 12 of this act, 40-2222a, 40-2222a, as amended by section 14 of this act, 40-2222b, 40-2222b, as amended by section 16 of this act, 40-2404, 40-3812, 40-3813, 40-3814 and 75-4101 and repealing the existing sections.

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

New Section 1. On and after July 1, 2019, the provisions of sections 1 through 3, and amendments thereto, shall be known and may be cited as the unclaimed life insurance benefits act.

New Sec. 2. As used in the unclaimed life insurance benefits act:

(a) "Contract" means an annuity contract. The term "contract" shall not include an annuity used to fund an employment-based retirement plan or program where: (1) The insurer does not perform the record-keeping services; or (2) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(b) "Death master file" means the United States social security administration's death master file or any other database or service that is at least as comprehensive as the United States social security administration's death master file for determining that a person has reportedly died.

(c) "Death master file match" means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner or retained asset account holder.

(d) "Knowledge of death" means: (1) Receipt of an original or valid copy of a certified death certificate; or (2) a death master file match validated by the insurer in accordance with section 3(a), and amendments thereto.

(e) "Policy" means any policy or certificate of life insurance that provides a death benefit. The term "policy" shall not include: (1) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan: (A) Subject to the employee retirement income security act of 1974 (29 U.S.C. § 1002); or (B) under any federal employee benefit program; (2) any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement; (3) any policy or certificate of credit life or accidental death insurance; or (4) any policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(f) "Record keeping services" means those circumstances under which the insurer has agreed with a group policy or contract customer to be responsible for obtaining, maintaining and administering in its own or its agents' systems information about each individual insured under an insured's group insurance contract, or a line of coverage thereunder, at least the following information: (1) Social security number or name and date of birth; (2) beneficiary designation information; (3) coverage eligibility; (4) benefit amount; and (5) premium payment status.

(g) "Retained asset account" means any mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

(h) The provisions of this section shall take effect on and after July 1, 2019.

New Sec. 3. (a) An insurer shall perform a comparison of its insureds' in-force policies, contracts, and retained asset accounts against a death master file, on at least a semi-annual basis, by using the full death master file once and thereafter using the death master file

update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of a death master file match, the insurer shall:

(1) Within 90 days of a death master file match:

(A) Complete a good faith effort that shall be documented by the insurer to confirm the death of the insured or retained asset account holder against other available records and information;

(B) determined whether benefits are due in accordance with the applicable policy or contract. If benefits are due in accordance with the applicable policy or contract:

(i) Use good faith efforts that shall all be documented by the insurer to locate the beneficiary or beneficiaries; and

(ii) provide the appropriate claim forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy contract.

(2) With respect to group life insurance, insurers shall confirm the possible death of an insured when the insurers maintain at least the following information of those covered under a policy or certificate: (A) Social security number or name and date of birth; (B) beneficiary designation information; (C) coverage eligibility; (D) benefit amount; and (E) premium payment status.

(3) Every insurer shall implement procedures to account for:

(A) Common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names and interchanged first and middle names;

(B) compound last names, maiden or married names, and hyphens, blank spaces or apostrophes in last names;

(C) transposition of the month and date portions of the date of birth; and

(D) incomplete social security numbers.

(4) To the extent permitted by law, the insurer may disclose minimum, necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(b) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(c) The benefits from a policy, contract or a retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners, and in the event the beneficiaries or owners can not be found, shall escheat to the state as unclaimed property pursuant to K.S.A. 58-3936, and amendments thereto. Interest payable under K.S.A. 40-447, and amendments thereto, shall not be payable as unclaimed property.

(d) An insurer shall notify the state treasurer upon the expiration of the statutory time period for escheat that:

(1) A policy or contract beneficiary or retained asset account holder has not submitted a claim with the insurer; and

(2) the insurer has complied with subsection (a) and has been unable, after good faith efforts, documented by the insurer, to contact the retained asset account holder, beneficiary or beneficiaries.

(e) Upon such notice, an insurer shall immediately submit the unclaimed policy or contract benefits or unclaimed retained asset accounts, plus any applicable accrued interest, to the state treasurer in accordance with the unclaimed property act.

(f) Failure to meet any requirement of this section with such frequency as to constitute a general business practice shall be considered an unfair or deceptive act or practice under K.S.A. 40-2404, and amendments thereto, and subject to the penalties contained under K.S.A. 40-2401 et seq., and amendments thereto. Nothing herein shall be construed to create or imply a private cause of action for a violation

of this section.

(g) The provisions of this section shall take effect on and after July 1, 2019.

Sec. 4. On and after July 1, 2019, K.S.A. 2018 Supp. 40-2404 is hereby amended to read as follows: 40-2404. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) *Misrepresentations and false advertising of insurance policies*. Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission or comparison ~~which~~ *that*:

(a) Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

(b) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(c) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy;

(d) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates;

(e) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(f) is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy;

(g) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or

(h) misrepresents any insurance policy as being shares of stock.

(2) *False information and advertising generally.* Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, misrepresentation or statement with respect to the business of insurance or with respect to any person in the conduct of such person's insurance business, ~~which~~ *that* is untrue, deceptive or misleading.

(3) *Defamation.* Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature ~~which~~ *that* is false, or maliciously critical of or derogatory to the financial condition of any person, and ~~which~~ *that* is calculated to injure such person.

(4) *Boycott, coercion and intimidation.* Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance, or by any act of boycott, coercion or intimidation monopolizing or attempting to monopolize any part of the business of insurance.

(5) *False statements and entries.* (a) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(b) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

(6) *Stock operations and advisory board contracts.* Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit

certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Nothing herein shall prohibit the acts permitted by K.S.A. 40-232, and amendments thereto.

(7) *Unfair discrimination.* (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(c) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. With respect to all other conditions, including the underlying cause of the blindness or partial blindness, persons who are blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons. Refusal to insure includes denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being presumed in the event that the insured loses such person's eyesight. However, an insurer may exclude from coverage disabilities consisting solely of blindness or partial blindness when such condition existed at the time the policy was issued.

(d) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for accident and health and life insurance to an applicant who is the proposed insured or charge a different rate for the same coverage or excluding or limiting coverage for losses or denying a claim incurred by an insured as a result of abuse based on the fact that the applicant who is the proposed insured is, has been, or may be the subject of domestic abuse, except as provided in ~~subpart (v)~~ *subsection (7)(d)(v)*. "Abuse" as used in this ~~subsection (7)(d)~~ *paragraph* means one or more acts defined in ~~subsection (a) or (b) of~~ K.S.A. 60-3102, and amendments thereto, between family members, current or former household members, or current or former intimate partners.

(i) An insurer may not ask an applicant for life or accident and health insurance who is the proposed insured if the individual is, has been or may be the subject of domestic abuse or seeks, has sought or had reason to seek medical or psychological treatment or counseling specifically for abuse, protection from abuse or shelter from abuse.

(ii) Nothing in this section shall be construed to prohibit a person from declining to issue an insurance policy insuring the life of an individual who is, has been or has the potential to be the subject of abuse if the perpetrator of the abuse is the applicant or would be the owner of the insurance policy.

(iii) No insurer that issues a life or accident and health policy to an individual who is, has been or may be the subject of domestic abuse shall be subject to civil or criminal liability for the death or any injuries suffered by that individual as a result of domestic abuse.

(iv) No person shall refuse to insure, refuse to continue to insure, limit the amount, extent or kind of coverage available to an individual or charge a different rate for the same coverage solely because of physical or mental condition, except where the refusal, limitation or rate differential is based on sound actuarial principles.

(v) Nothing in this section shall be construed to prohibit a person from underwriting or rating a risk on the basis of a preexisting physical or mental condition, even if such condition has been caused by abuse,

provided that:

(A) The person routinely underwrites or rates such condition in the same manner with respect to an insured or an applicant who is not a victim of abuse;

(B) the fact that an individual is, has been or may be the subject of abuse may not be considered a physical or mental condition; and

(C) such underwriting or rating is not used to evade the intent of this section or any other provision of the Kansas insurance code.

(vi) Any person who underwrites or rates a risk on the basis of preexisting physical or mental condition as set forth in subsection (7)(d)(v), shall treat such underwriting or rating as an adverse underwriting decision pursuant to K.S.A. 40-2,112, and amendments thereto.

(vii) The provisions of ~~subsection (d)~~ *this paragraph* shall apply to all policies of life and accident and health insurance issued in this state after the effective date of this act and all existing contracts ~~which~~ *that* are renewed on or after the effective date of this act.

(e) Refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available for life insurance to an individual, or charging an individual a different rate for the same coverage, solely because of such individual's status as a living organ donor. With respect to all other conditions, persons who are living organ donors shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are persons who are not organ donors.

(8) *Rebates.* (a) Except as otherwise expressly provided by law, knowingly permitting, offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the insurance contract issued thereon; paying, allowing, giving or offering to pay, allow or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, selling, purchasing or offering to give, sell or purchase as inducement to such insurance contract or annuity or in connection therewith, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract.

(b) Nothing in subsection (7) or (8)(a) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance. Any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount ~~which~~ *that* fairly represents the saving in collection expenses; or

(iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(9) *Unfair claim settlement practices.* It is an unfair claim settlement practice if any of the following or any rules and regulations pertaining thereto are ~~:~~ ~~(A)~~ *either* committed flagrantly and in conscious disregard of such provisions, or ~~(B)~~ committed with such frequency as to indicate a general business practice ~~.~~*:*

(a) Misrepresenting pertinent facts or insurance policy provisions

relating to coverages at issue;

(b) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(c) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(d) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(e) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(f) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(g) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(h) attempting to settle a claim for less than the amount to which a reasonable person would have believed that such person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(i) attempting to settle claims on the basis of an application ~~which~~ *that* was altered without notice to, or knowledge or consent of the insured;

(j) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

(k) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(l) delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(m) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; or

(n) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(10) *Failure to maintain complaint handling procedures.* Failure of any person, who is an insurer on an insurance policy, to maintain a complete record of all the complaints ~~which~~ *that* it has received since the date of its last examination under K.S.A. 40-222, and amendments thereto; but no such records shall be required for complaints received prior to the effective date of this act. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, the date each complaint was originally received by the insurer and the date of final disposition of each complaint. For purposes of this subsection, "complaint" means any written communication primarily expressing a grievance related to the acts and practices set out in this section.

(11) *Misrepresentation in insurance applications.* Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money or other benefit from any insurer, agent, broker or individual.

(12) *Statutory violations.* Any violation of any of the provisions of K.S.A. 40-216, 40-276a, 40-2,155 or 40-1515, and amendments thereto.

(13) *Disclosure of information relating to adverse underwriting decisions and refund of premiums.* Failing to comply with the provisions of K.S.A. 40-2,112, and amendments thereto, within the

time prescribed in such section.

(14) *Rebates and other inducements in title insurance.* (a) No title insurance company or title insurance agent, or any officer, employee, attorney, agent or solicitor thereof, may pay, allow or give, or offer to pay, allow or give, directly or indirectly, as an inducement to obtaining any title insurance business, any rebate, reduction or abatement of any rate or charge made incident to the issuance of such insurance, any special favor or advantage not generally available to others of the same classification, or any money, thing of value or other consideration or material inducement. The words "charge made incident to the issuance of such insurance" includes, without limitations, escrow, settlement and closing charges.

(b) No insured named in a title insurance policy or contract nor any other person directly or indirectly connected with the transaction involving the issuance of the policy or contract, including, but not limited to, mortgage lender, real estate broker, builder, attorney or any officer, employee, agent representative or solicitor thereof, or any other person may knowingly receive or accept, directly or indirectly, any rebate, reduction or abatement of any charge, or any special favor or advantage or any monetary consideration or inducement referred to in *subsection* (14)(a).

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

(i) The payment of reasonable fees for services actually rendered to a title insurance agent in connection with a title insurance transaction;

(ii) the payment of an earned commission to a duly appointed title insurance agent for services actually performed in the issuance of the policy of title insurance; or

(iii) the payment of reasonable entertainment and advertising expenses.

(d) Nothing in this section prohibits the division of rates and charges between or among a title insurance company and its agent, or one or more title insurance companies and one or more title insurance agents, if such division of rates and charges does not constitute an unlawful rebate under the provisions of this section and is not in payment of a forwarding fee or a finder's fee.

(e) As used in ~~paragraphs (c) through (i)(7) of this subpart~~ *subsections (14)(e) through (14)(i)*, unless the context otherwise requires:

(i) "Associate" means any firm, association, organization, partnership, business trust, corporation or other legal entity organized for profit in which a producer of title business is a director, officer or partner thereof, or owner of a financial interest; the spouse or any relative within the second degree by blood or marriage of a producer of title business who is a natural person; any director, officer or employee of a producer of title business or associate; any legal entity that controls, is controlled by, or is under common control with a producer of title business or associate; and any natural person or legal entity with whom a producer of title business or associate has any agreement, arrangement or understanding or pursues any course of conduct, the purpose or effect of which is to evade the provisions of this section.

(ii) "Financial interest" means any direct or indirect interest, legal or beneficial, where the holder thereof is or will be entitled to 1% or more of the net profits or net worth of the entity in which such interest is held. Notwithstanding the foregoing, an interest of less than 1% or any other type of interest shall constitute a "financial interest" if the primary purpose of the acquisition or retention of that interest is the financial benefit to be obtained as a consequence of that interest from the referral of title business.

(iii) "Person" means any natural person, partnership, association, cooperative, corporation, trust or other legal entity.

(iv) "Producer of title business" or "producer" means any person, including any officer, director or owner of 5% or more of the equity or capital or both of any person, engaged in this state in the trade,

business, occupation or profession of:

(A) Buying or selling interests in real property;

(B) making loans secured by interests in real property; or

(C) acting as broker, agent, representative or attorney for a person who buys or sells any interest in real property or who lends or borrows money with such interest as security.

(v) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral.

(f) No title insurer or title agent may accept any order for, issue a title insurance policy to, or provide services to, an applicant if it knows or has reason to believe that the applicant was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed to the buyer, seller and lender the financial interest of the producer of title business or associate referring the title insurance business.

(g) No title insurer or title agent may accept an order for title insurance business, issue a title insurance policy, or receive or retain any premium, or charge in connection with any transaction if: (i) The title insurer or title agent knows or has reason to believe that the transaction will constitute controlled business for that title insurer or title agent~~,~~*;* and (ii) 70% or more of the closed title orders of that title insurer or title agent during the 12 full calendar months immediately preceding the month in which the transaction takes place is derived from controlled business. The prohibitions contained in this ~~subparagraph~~ *paragraph* shall not apply to transactions involving real estate located in a county that has a population, as shown by the last preceding decennial census, of 10,000 or less.

(h) Within 90 days following the end of each business year, as established by the title insurer or title agent, each title insurer or title agent shall file with the department of insurance and any title insurer with which the title agent maintains an underwriting agreement, a report executed by the title insurer's or title agent's chief executive officer or designee, under penalty of perjury, stating the percent of closed title orders originating from controlled business. The failure of a title insurer or title agent to comply with the requirements of this section, at the discretion of the commissioner, shall be grounds for the suspension or revocation of a license or other disciplinary action, with the commissioner able to mitigate any such disciplinary action if the title insurer or title agent is found to be in substantial compliance with competitive behavior as defined by federal housing and urban development statement of policy 1996-2.

(i) (1) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person if it knows or has reason to believe that such person was referred to it by any producer of title business or by any associate of such producer, where the producer, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred unless the producer has disclosed in writing to the person so referred the fact that such producer or associate has a financial interest in the title insurer or title agent, the nature of the financial interest and a written estimate of the charge or range of charges generally made by the title insurer or agent for the title services. Such disclosure shall include language stating that the consumer is not obligated to use the title insurer or agent in which the referring producer or associate has a financial interest and shall include the names and telephone numbers of not less than three other title insurers or agents ~~which~~ *that* operate in the county in which the property is located. If fewer than three insurers or agents operate in that county, the disclosure shall include all title insurers or agents operating in that county. Such written disclosure shall be signed by the person so referred and must have occurred prior to any commitment having been

made to such title insurer or agent.

(2) No producer of title business or associate of such producer shall require, directly or indirectly, as a condition to selling or furnishing any other person any loan or extension thereof, credit, sale, property, contract, lease or service, that such other person shall purchase title insurance of any kind through any title agent or title insurer if such producer has a financial interest in such title agent or title insurer.

(3) No title insurer or title agent may accept any title insurance order or issue a title insurance policy to any person it knows or has reason to believe that the name of the title company was pre-printed in the sales contract, prior to the buyer or seller selecting that title company.

(4) Nothing in this ~~subpart (i)~~ *paragraph* shall prohibit any producer of title business or associate of such producer from referring title business to any title insurer or title agent of such producer's or associate's choice, and, if such producer or associate of such producer has any financial interest in the title insurer, from receiving income, profits or dividends produced or realized from such financial interest, so long as:

(a) Such financial interest is disclosed to the purchaser of the title insurance in accordance with ~~part~~ *paragraphs* (i)(1) through *(i)*(4) ~~of this subpart~~;

(b) the payment of income, profits or dividends is not in exchange for the referral of business; and

(c) the receipt of income, profits or dividends constitutes only a return on the investment of the producer or associate.

(5) Any producer of title business or associate of such producer who violates the provisions of paragraphs (i)(2) through (i)(4), or any title insurer or title agent who accepts an order for title insurance knowing that it is in violation of paragraphs (i)(2) through (i)(4), in addition to any other action ~~which~~ *that* may be taken by the commissioner of insurance, shall be subject to a fine by the commissioner in an amount equal to five times the premium for the title insurance and, if licensed pursuant to K.S.A. 58-3034 et seq., and amendments thereto, shall be deemed to have committed a prohibited act pursuant to K.S.A. 58-3602, and amendments thereto, and shall be liable to the purchaser of such title insurance in an amount equal to the premium for the title insurance.

(6) Any title insurer or title agent that is a competitor of any title insurer or title agent that, subsequent to the effective date of this act, has violated or is violating the provisions of ~~subpart (i)~~ *this paragraph*, shall have a cause of action against such title insurer or title agent and, upon establishing the existence of a violation of any such provision, shall be entitled, in addition to any other damages or remedies provided by law, to such equitable or injunctive relief as the court deems proper. In any such action under this subsection, the court may award to the successful party the court costs of the action together with reasonable attorney fees.

(7) The commissioner shall also require each title agent to provide core title services as required by the real estate settlement procedures act.

(j) The commissioner shall adopt any regulations necessary to carry out the provisions of this act.

(15) *Disclosure of nonpublic personal information.* (a) No person shall disclose any nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley act of 1999 (public law 106-102). The commissioner may adopt rules and regulations necessary to carry out this ~~section~~ *subsection*. Such rules and regulations shall be consistent with and not more restrictive than the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation".

(b) ~~Any rules and regulations adopted by the commissioner which~~

~~implement article V of the model regulation adopted on September 26, 2000, by the national association of insurance commissioners entitled "Privacy of consumer financial and health information regulation" shall become effective on and after February 1, 2002.~~

~~(c)~~ Nothing in this ~~paragraph (15)~~ *subsection* shall be deemed or construed to authorize the promulgation or adoption of any regulation ~~which~~ *that* preempts, supersedes or is inconsistent with any provision of Kansas law concerning requirements for notification of, or obtaining consent from, a parent, guardian or other legal custodian of a minor relating to any matter pertaining to the health and medical treatment for such minor.

Sec. 5. On and after July 1, 2019, K.S.A. 2018 Supp. 40-3812 is hereby amended to read as follows: 40-3812. (a) A person shall apply to be an administrator in its home state and shall receive a license from the regulatory authority of its home state prior to performing any function of an administrator in this state.

(b) A person applying to Kansas as its home state shall apply for licensure by submitting to the commissioner an application in the form prescribed by the commissioner that shall include or be accompanied by the following information and documents:

(1) All basic organizational documents of the applicant, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, certificate of existence from the Kansas secretary of state and other applicable documents and all amendments to such documents;

(2) the bylaws, rules, regulations or similar documents regulating the internal affairs of the applicant;

(3) NAIC biographical affidavits for the individuals who are directly or indirectly responsible for the conduct of affairs of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers in the case of a corporation or the partners or members in the case of a partnership, association or limited liability company, any shareholders or members holding directly or indirectly 10% or more of the voting stock, voting securities or voting interest of the applicant and any other person who directly or indirectly exercises control or influence over the affairs of the applicant;

(4) audited annual financial statements or reports for the two most recent fiscal years that demonstrate that the applicant has a positive net worth. If the applicant has been in existence for less than two fiscal years, the uniform application shall include financial statements or reports, certified by at least two officers, owners or directors of the applicant and prepared in accordance with GAAP, for any completed fiscal years and for any month during the current fiscal year for which such financial statements or reports have been completed. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(A) Amounts shown on the consolidated audited financial report shown on the worksheet;

(B) amounts for each entity stated separately; and

(C) explanations of consolidating and eliminating entries included.

The applicant shall also include such other information as the commissioner may require in order to review the current financial condition of the applicant;

(5) in lieu of submitting audited financial statements, and upon written application by an applicant and good cause shown, the commissioner may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, that shall include notes, are:

(A) Reports compiled or reviewed by a certified public accountant; or

(B) internal financial reports prepared in accordance with GAAP, certified by at least two officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the applicant must also secure and maintain a surety bond in a form prescribed by the commissioner for the use and benefit of the commissioner to be held in trust for the benefit and protection of covered persons and any payor or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of 10% of funds handled for the benefit of Kansas residents or $20,000. Administrators of self-funded plans in Kansas are subject to the mandatory surety bond requirement found in subsection (h), regardless of whether they file audited or unaudited financial reports;

(6) a statement describing the business plan, including information on staffing levels and activities, proposed in this state and nationwide. The plan shall provide details setting forth the applicant's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting;

(7) ~~the~~ *a* license application fee ~~as provided for by rules and regulations~~ *in the amount of $400*; and

(8) such other pertinent information as may be required by the commissioner.

(c) An administrator licensed or applying for licensure under the provisions of this section shall make available for inspection by the commissioner, copies of all contracts with payors or other persons utilizing the services of the administrator.

(d) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for examination, and makes its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

(e) The commissioner may refuse to issue a license if the commissioner determines that the applicant or any individual responsible for the conduct of affairs of the applicant is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator certificate of authority or license denied or revoked for cause by any jurisdiction, or if the commissioner determines that any of the grounds set forth in K.S.A. 40-3810, and amendments thereto, exist with respect to the applicant.

(f) A license issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the administrator continues in business in this state and remains in compliance with the provisions of this act and any applicable rules and regulations.

(g) An administrator licensed or applying for licensure under the provisions of this section shall immediately notify the commissioner of any material change in its ownership, control or other fact or circumstance affecting its qualification for a license in this state.

(h) An administrator licensed or applying for a home state license that administers or will administer governmental or church self-insured plans in this state or any other state shall maintain a surety bond for the use and benefit of the commissioner to be held in trust for the benefit and protection of covered persons and any payor or self-funded plan against loss by reason of acts of fraud or dishonesty. The bond shall be in the greater of the following amounts:

(1) $100,000; or

(2) an amount equal to 10% of the aggregate total amount of self-funded coverage under church plans or governmental plans handled in this state and all additional states in which the administrator is authorized to do business.

Sec. 6. On and after July 1, 2019, K.S.A. 2018 Supp. 40-3813 is hereby amended to read as follows: 40-3813. (a) Unless an administrator has obtained a home state license in this state, any

administrator who performs duties as an administrator in this state shall obtain a nonresident administrator license in accordance with the provisions of this section by filing with the commissioner the uniform application, accompanied by a letter of certification. In lieu of requiring an administrator to file a letter of certification with the uniform application, the commissioner may verify the nonresident administrator's home state certificate of authority or license status through an electronic database maintained by the NAIC, its affiliates or subsidiaries.

(b) An administrator shall not be eligible for a nonresident administrator license under the provisions of this section if it does not hold a license in a home state that has adopted a substantially similar law governing administrators.

(c) Except as provided in subsections (b) and (h) the commissioner shall issue to the administrator a nonresident administrator license promptly upon receipt of a complete application.

(d) Each nonresident administrator shall file biennially, as a part of its application for renewal of its license, a statement that its home state administrator license remains in force and has not been revoked or suspended by its home state during the preceding years. *Each nonresident administrator renewal application shall be accompanied by a renewal application fee in the amount of $200.*

(e) At the time of filing the application for licensing required under the provisions of this section, the nonresident administrator shall pay a license application fee ~~as provided for by rules and regulations~~ *in the amount of $400*.

(f) An administrator licensed or applying for licensure under the provisions of this section shall produce its accounts, records and files for examination, and make its officers available to give information with respect to its affairs, as often as reasonably required by the commissioner.

(g) A nonresident administrator is not required to hold a nonresident administrator license in this state if the administrator is licensed in its home state and the administrator's duties in this state are limited to:

(1) The administration of a group policy or plan and no more than a total of 20% of covered persons, for all plans the administrator services, reside in this state; and

(2) the total number of covered persons residing in this state is less than 100.

(h) The commissioner may refuse to issue a nonresident administrator license, or delay the issuance of a nonresident administrator license, if the commissioner determines that, due to events or information obtained subsequent to the home state's licensure of the administrator, the nonresident administrator cannot satisfy the requirements of this act or that grounds exist for the home state's revocation or suspension of the administrator's home state certificate of authority or license.

Sec. 7. On and after July 1, 2019, K.S.A. 2018 Supp. 40-3814 is hereby amended to read as follows: 40-3814. (a) Each administrator licensed under the provisions of this act shall file an annual report for the preceding calendar year with the commissioner on or before July 1 of each year, or within such extension of time as the commissioner may grant for good cause*, accompanied by an annual report fee in the amount of $100*. The annual report shall include:

(1) An audited financial statement attested to by an independent certified public accountant. An audited annual financial report prepared on a consolidated basis shall include a columnar consolidating or combining worksheet that shall be filed with the report and include the following:

(A) Amounts shown on the consolidated audited financial report shown on the worksheet;

(B) amounts for each entity stated separately; and

(C) explanations of consolidating and eliminating entries included.

(2) In lieu of submitting an audited financial statement, and upon written application by an administrator and good cause shown, the commissioner may grant a hardship exemption from filing audited financial statements and allow the submission of unaudited financial statements. Acceptable formats for unaudited financial statements, that shall include notes, are:

(A) Reports compiled or reviewed by a certified public accountant; or

(B) internal financial reports prepared in accordance with GAAP, certified by at least two officers, owners or directors of the administrator.

If unaudited financial statements are submitted, the administrator must secure and maintain a surety bond in a form prescribed by the commissioner for the use and benefit of the commissioner to be held in trust for the benefit and protection of covered persons and any payor or self-funded plan against loss by reason of acts of fraud or dishonesty, for the greater of 10% of funds handled for the benefit of Kansas residents or $20,000.

(b) The annual report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two officers, owners or directors of the administrator.

(c) The annual report shall include the complete names and addresses of all payors and for self-funded plans, all employers and trusts, with which the administrator had agreements during the preceding fiscal year. The report shall also include the number of Kansas residents covered by each of the plans.

Sec. 8. K.S.A. 2018 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~~ *paragraph* (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~~ *that* 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~~ *that* offers such policy ~~which~~ *that* 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~~ *that* 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~~ *that* 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)~~ *paragraph* (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~~ *subsection* (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~~ *that* is offered through an association or trust pursuant to ~~subsections~~ *subsection* (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~~ *that* 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~~ *that* 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~~ *that* 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)~~ *(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)~~*; and (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~~ *that* 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~~ *that* 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~~ *that* 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~~ *that* 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~~ *that* 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~~ *that* 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 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~~ *subparagraph* (A)(i) ~~above~~ for such person or benefits provided or available under the sources referred to in ~~clauses~~ *subparagraphs* (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~~ *paragraph (6)* (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)*(A)(iii)* 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~~ *that* 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~~ *the amount described in clause* (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~~ *that* 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~~ *that* 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~~ *subparagraph* (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~~ *subparagraph* (A)(i) ~~of this~~

~~paragraph~~ or 24 months when the maximum benefit is determined by ~~clause~~ *subparagraph* (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 deductible 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~~ *that* 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~~ *that* is delivered outside this state must be on a form~~ which~~ *that* 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~~ *that* 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. 9. K.S.A. 40-2209b is hereby amended to read as follows: 40-2209b. *(a) The provisions of K.S.A. 40-2209b through 40-2209j and 40-2209m through 40-2209o, and amendments thereto, shall be known and may be cited as the small employer health insurance availability act.*

(b) The purpose and intent of ~~this~~ *the small employer health insurance availability* act are to promote the availability of health insurance coverage to small employers regardless of their health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitations on the use of pre-existing condition exclusions, to provide for development of "basic" and "standard" health benefit plans to be offered to all small employers, to provide for establishment of a reinsurance program, and to improve the overall fairness and efficiency of the small group health insurance market.

Sec. 10. K.S.A. 2018 Supp. 40-2209d is hereby amended to read as follows: 40-2209d. As used in ~~this~~ *the small employer health insurance availability* act:

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

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

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

(d) "Carrier" or "small employer carrier" means any insurance company, nonprofit medical and hospital service corporation, nonprofit optometric, dental, and pharmacy service corporations, municipal group-funded pool, fraternal benefit society or health maintenance organization, as these terms are defined ~~by~~ *in chapter 40 of* the Kansas Statutes Annotated, *and amendments thereto,* that offers health benefit plans covering eligible employees of one or more small employers in

this state.

(e) "Case characteristics" means, with respect to a small employer, the geographic area in which the employees reside; the age and sex of the individual employees and their dependents; the appropriate industry classification as determined by the carrier, and the number of employees and dependents and such other objective criteria as may be approved family composition by the commissioner. "Case characteristics" shall not include claim experience, health status and duration of coverage since issue.

(f) "Class of business" means all or a separate grouping of small employers established pursuant to K.S.A. 40-2209g, and amendments thereto.

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

(h) "Department" means the insurance department.

(i) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefits plan covering such employee and the dependent eligibility standards established by the board.

(j) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided such sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer but does not include an employee who works on a part-time, temporary or substitute basis.

(k) "Financially impaired" means a member which, after the effective date of this act, is not insolvent but is:

(1) Deemed by the commissioner to be in a hazardous financial condition pursuant to K.S.A. 40-222d, and amendments thereto; or

(2) placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(l) "Health benefit plan" 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 benefit plan″ also includes a cafeteria plan authorized by 26 U.S.C. ~~section~~ *§* 125 ~~which~~ *that* offers the option of receiving health insurance coverage through a high deductible health plan and the establishment of a health savings account. In order for an eligible individual to obtain a high deductible health plan through the cafeteria plan, such individual shall present evidence to the employer that such individual has established a health savings account in compliance with 26 U.S.C. ~~section~~ *§* 223, and any ~~amendments and~~ regulations *promulgated thereunder.* "Health benefit plan" 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 savings account" ~~shall have the same meaning ascribed to it~~ *means the same* as in ~~subsection (d) of~~ 26 U.S.C. ~~section~~ *§* 223*(d)*.

(n) "High deductible health plan" ~~shall mean~~ *means* a policy or contract of health insurance or health care plan that meets the criteria established in ~~subsection (c) of~~ 26 U.S.C. ~~section~~ *§* 223*(c)* and any regulations promulgated thereunder.

(o) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(p) "Initial enrollment period" means the period of time specified in the health benefit plan during which an individual is first eligible to enroll in a small employer health benefit plan. Such period shall be no less favorable than a period beginning on the employee's or member's date of initial eligibility and ending 31 days thereafter.

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

(1) The individual:

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

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

(C) has lost coverage under another employer health benefit plan or under section 607(1) of the employee retirement income security act of 1974 (ERISA) as a result of the termination of employment, reduction in the number of hours of employment, termination of employer contributions toward such coverage, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation; and

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

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

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

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

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

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

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

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

(w) "Small employer" means any person, firm, corporation~~,~~ *or* partnership ~~or association~~ eligible for group sickness and accident insurance pursuant to ~~subsection (a) of~~ K.S.A. 40-2209, and amendments thereto, actively engaged in business whose total employed work force consisted of, on at least 50% of its working days during the preceding year, of at least two and no more than 50 eligible

employees, the majority of whom were employed within the state. In determining the number of eligible employees, *employees participating in an association health plan shall be counted in the aggregate at the association level. Also in determining the number of eligible employees* companies ~~which~~ *that* are affiliated companies or ~~which~~ *that* are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, *the* provisions of ~~this act which~~ *the small employer health insurance availability act* apply to a small employer ~~which~~ *that* has a health benefit plan shall continue to apply until the plan anniversary following the date the employer no longer meets the requirements of this definition.

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

(y) "Association health plan" or "AHP" means a coverage for the payment of expenses described in K.S.A. 40-2222, and amendments thereto, offered by a qualified trade, merchant, retail or professional association or business league that complies with the provisions of K.S.A. 40-2222a and 40-2222b, and amendments thereto.

(z) "Qualified trade, merchant, retail or professional association or business league" means any bona fide trade merchant, retail or professional association or business league that: (1) Has been in existence for at least five calendar years; (2) is comprised of five or more employers; and (3) is incorporated in this state, has a principal office located in this state, or has a principal office within a metropolitan area that has boundaries within this state.

Sec. 11. K.S.A. 40-2209e is hereby amended to read as follows: 40-2209e. (a) Any individual or group health benefit plan issued to a group authorized by ~~subsection (a) of~~ K.S.A. 40-2209*(a)*, and amendments thereto, shall be subject to the provisions of this act if it provides health care benefits covering employees of a small employer and if it meets any one of the following conditions:

(1) Any portion of the premium is paid by a small employer, or any covered individual, whether through wage adjustments, reimbursement, withholding or otherwise;

(2) the health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 106 or section 162 of the United States internal revenue code; or

(3) with the permission of the board, the carrier elects to renew or continue a health benefit plan covering employees of an employer who no longer meets the definition of a "small employer."

(b) ~~For purposes of this act an aggregation of two or more small employers covered under a trust arrangement or a policy issued to an association of small employers pursuant to K.S.A. 40-2209, and amendments thereto, shall permit employee or member units of more than two but less than 51 employees or members and their dependents to participate in any health benefit plan to which this act applies. Any group which includes employee or member units of 50 or fewer employees shall be subject to the provisions of this act notwithstanding its inclusion of employee or member units with more than 50 employees or members.~~

~~(c)~~ Except as expressly provided in this act, no health benefit plan offered to a small employer shall be subject to:

(1) Any law that would inhibit any carrier from contracting with providers or groups of providers with respect to health care services or benefits;

(2) any law that would impose any restriction on the ability to negotiate with providers regarding the level or method of reimbursing care or services provided under the health benefit plan.

~~(d)~~*(c)* Individual policies of accident and sickness insurance issued to individuals and their dependents totally independent of any

group, association or trust arrangement permitted under K.S.A. 40-2209, and amendments thereto, shall not be subject to the provisions of this act.

Sec. 12. K.S.A. 2018 Supp. 40-2222 is hereby amended to read as follows: 40-2222. (a) Any person or other entity ~~which~~ *that* provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance unless the person or other entity:

(1) Is a professional association of architects incorporated in Kansas on October 4, 1954, ~~which~~ *that* provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established November 1, 1986, and complies with K.S.A. 40-2222a, and amendments thereto;

(2) is a professional association of dentists incorporated in Kansas on July 3, 1972, ~~which~~ *that* provides coverage for the payment of expenses described herein to or for the members of the association or dependents through ~~a~~ *an established* trust ~~established November 1, 1985,~~ and complies with K.S.A. 40-2222a, and amendments thereto;

(3) (A) is a trade association of banks incorporated in Kansas on August 9, 1978, ~~which~~ *that* provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established July 1, 1989, and complies with K.S.A. 40-2222a, and amendments thereto; or

(B) is a trade organization of banks incorporated in Kansas on June 1, 1982, ~~which~~ *that* provides coverage for expenses described herein to or for members of the association or dependents, and complies with K.S.A. 40-2222a, and amendments thereto;

(4) is a trade association of truckers incorporated in Kansas on July 1, 1985, ~~which~~ *that* provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established January 1, 1990, and complies with K.S.A. 40-2222a, and amendments thereto;

(5) is an association of physicians practicing in the Kansas City metropolitan area, incorporated in Missouri on March 5, 1891, and qualified as a foreign corporation in Kansas on May 19, 1987, ~~which~~ *that* provides coverage for the payment of expenses described herein to or for the members of the association, their employees and dependents through a trust established November 1, 1984, and complies with K.S.A. 40-2222a, and amendments thereto;

(6) is organized as a farmers' cooperative under the Kansas cooperative marketing act, K.S.A. 17-1601 et seq., and amendments thereto, on January 13, 1983, and is an association of farmers' cooperatives and other like associations operated on a cooperative basis and their affiliated companies, ~~which~~ *that* provides benefits for employees, and family members of such employees, of such associations, and complies with K.S.A. 40-2222a, and amendments thereto;

(7) is any other qualified trade, merchant, retail, or professional association or business league ~~incorporated in Kansas which~~ *that provides coverage for the payment of expenses described herein to or for the members of the association, their employees and dependents and that* complies with K.S.A. 40-2222a, and amendments thereto;

(8) conclusively shows by submission of an appropriate certificate, license, letter or other document issued by the United States department of labor that such person or entity is not subject to Kansas law; or

(9) conclusively shows that it is subject to the jurisdiction of an agency of this state or the federal government. For purposes of this act, tax exempt status under section 501(c) of the federal internal revenue code of 1986 shall not be deemed to be jurisdiction of the federal government.

(b) For the purposes of this section, a qualified trade, merchant, retail or professional association or business league ~~shall mean any bona fide trade, merchant, retail or professional association or business league that:~~

~~(1) Has been in existence for at least five calendar years; and~~

~~(2) is comprised of five or more employers~~ *means the same as in K.S.A. 40-2209d, and amendments thereto*.

Sec. 13. On and after July 1, 2019, K.S.A. 2018 Supp. 40-2222, as amended by section 12 of this act, is hereby amended to read as follows: 40-2222. (a) Any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance unless the person or other entity:

(1) Is a professional association of architects incorporated in Kansas on October 4, 1954, that provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established November 1, 1986, and complies with K.S.A. 40-2222a, and amendments thereto;

(2) is a professional association of dentists incorporated in Kansas on July 3, 1972, that provides coverage for the payment of expenses described herein to or for the members of the association or dependents through an established trust and complies with K.S.A. 40-2222a, and amendments thereto;

(3) (A) is a trade association of banks incorporated in Kansas on August 9, 1978, that provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established July 1, 1989, and complies with K.S.A. 40-2222a, and amendments thereto; or

(B) is a trade organization of banks incorporated in Kansas on June 1, 1982, that provides coverage for expenses described herein to or for members of the association or dependents, and complies with K.S.A. 40-2222a, and amendments thereto;

(4) is a trade association of truckers incorporated in Kansas on July 1, 1985, that provides coverage for the payment of expenses described herein to or for the members of the association or dependents through a trust established January 1, 1990, and complies with K.S.A. 40-2222a, and amendments thereto;

(5) is an association of physicians practicing in the Kansas City metropolitan area, incorporated in Missouri on March 5, 1891, and qualified as a foreign corporation in Kansas on May 19, 1987, that provides coverage for the payment of expenses described herein to or for the members of the association, their employees and dependents through a trust established November 1, 1984, and complies with K.S.A. 40-2222a, and amendments thereto;

(6) is organized as a farmers' cooperative under the Kansas cooperative marketing act, K.S.A. 17-1601 et seq., and amendments thereto, on January 13, 1983, and is an association of farmers' cooperatives and other like associations operated on a cooperative basis and their affiliated companies, that provides benefits for employees, and family members of such employees, of such associations, and complies with K.S.A. 40-2222a, and amendments thereto;

(7) is any other qualified trade, merchant, retail, or professional association or business league that provides coverage for the payment of expenses described herein to or for the members of the association, their employees and dependents and that complies with K.S.A. 40-2222a, and amendments thereto;

(8) conclusively shows by submission of an appropriate certificate, license, letter or other document issued by the United States department of labor that such person or entity is not subject to Kansas law; or

(9) conclusively shows that it is subject to the jurisdiction of an

agency of this state or the federal government. For purposes of this act, tax exempt status under section 501(c) of the federal internal revenue code of 1986 shall not be deemed to be jurisdiction of the federal government.

(10) is a nonprofit agricultural membership organization incorporated in Kansas on June 23, 1931, or an affiliate thereof, that provides healthcare benefit coverage for the payment of expenses described herein to or for the members of the organization and their dependents. Notwithstanding any provision of law to the contrary, the healthcare benefit coverage described in this paragraph shall not be considered insurance. The risk under such coverage may be reinsured by a company authorized to conduct reinsurance in Kansas. Providers of healthcare benefit coverage shall file a signed, certified actuarial statement of plan reserves annually with the commissioner of insurance.

(b) For the purposes of this section, a qualified trade, merchant, retail or professional association or business league means the same as in K.S.A. 40-2209d, and amendments thereto.

Sec. 14. K.S.A. 2018 Supp. 40-2222a is hereby amended to read as follows: 40-2222a. At the time the initial application for coverage is taken with respect to new applicants and upon the first renewal, reinstatement or extension of coverage following the effective date of this act with respect to persons previously covered, each association described in ~~subsection (a) of~~ K.S.A. 40-2222, and amendments thereto, shall provide a written notice stating that:

(a) The coverage is not provided by an insurance company;

(b) the plan is not subject to the laws and regulations relating to insurance companies;

(c) the plan is not under the jurisdiction of the commissioner of insurance; and

(d) if the plan does not pay medical expenses that are eligible for payment under the plan for any reason, the individuals covered by the plan may be liable for such expenses.

Sec. 15. On and after July 1, 2019, K.S.A. 2018 Supp. 40-2222a, as amended by section 14 of this act, is hereby amended to read as follows: 40-2222a. At the time the initial application for coverage is taken with respect to new applicants and upon the first renewal, reinstatement or extension of coverage following the effective date of this act with respect to persons previously covered, each ~~association~~ *person or entity* described in K.S.A. 40-2222, and amendments thereto, shall provide a written notice stating that:

(a) The coverage is not provided by an insurance company;

(b) the plan is not subject to the laws and regulations relating to insurance companies;

(c) the plan is not under the jurisdiction of the commissioner of insurance; and

(d) if the plan does not pay medical expenses that are eligible for payment under the plan for any reason, the individuals covered by the plan may be liable for such expenses.

Sec. 16. K.S.A. 2018 Supp. 40-2222b is hereby amended to read as follows: 40-2222b. (a) As a condition precedent to continuation of the exemption provided by K.S.A. 40-2222, and amendments thereto, each association described in ~~subsection (a) of~~ K.S.A. 40-2222, and amendments thereto, shall, no later than May 1 of each year, pay a tax at the rate of 1% per annum upon the annual Kansas gross premium collected during the preceding calendar year. *For associations that have a principal office within a metropolitan area that has boundaries in Kansas and associations that have their principal office located within the borders of this state and offer policies to non-residents of Kansas, the tax owed under this section shall be based upon the gross premium collected during the preceding year relating to health benefit plans issued to members that have a principal place of business in Kansas.* In the computation of the tax, such associations shall be entitled to deduct any annual Kansas gross premiums returned on

account of cancellation or dividends returned to members or expenditures used for the purchase of reinsurance or stop-loss coverage.

(b) Every association subject to taxation under the provisions of this section shall pay the tax imposed and make a return under oath to the commissioner of insurance under such rules and regulations and in such form and manner as the commissioner may prescribe.

Sec. 17. On and after July 1, 2019, K.S.A. 2018 Supp. 40-2222b, as amended by section 16 of this act, is hereby amended to read as follows: 40-2222b. (a) As a condition precedent to continuation of the exemption provided by K.S.A. 40-2222, and amendments thereto, each ~~association~~ *person or entity* described in K.S.A. 40-2222, and amendments thereto, shall, no later than May 1 of each year, pay a tax at the rate of 1% per annum upon the annual Kansas gross premium collected during the preceding calendar year. For ~~associations~~ *persons or entities* that have a principal office within a metropolitan area that has boundaries in Kansas and associations that have their principal office located within the borders of this state and offer policies to non-residents of Kansas, the tax owed under this section shall be based upon the gross premium collected during the preceding year relating to health benefit plans issued to members that have a principal place of business in Kansas. In the computation of the tax, such ~~associations~~ *persons or entities* shall be entitled to deduct any annual Kansas gross premiums returned on account of cancellation or dividends returned to members or expenditures used for the purchase of reinsurance or stop-loss coverage.

(b) Every ~~association~~ *person or entity* subject to taxation under the provisions of this section shall pay the tax imposed and make a return under oath to the commissioner of insurance under such rules and regulations and in such form and manner as the commissioner may prescribe.

Sec. 18. K.S.A. 2018 Supp. 75-4101 is hereby amended to read as follows: 75-4101. (a) There is hereby created a committee on surety bonds and insurance, which shall consist of the state treasurer, the attorney general and the commissioner of insurance or their respective designees. The commissioner of insurance shall be the chairperson of the committee and the director of purchases or the director's designee shall be *the* ex officio secretary. The committee shall meet ~~on~~ *upon the* call of the chairperson and at such other times as the committee shall determine but at least once each month on the second Monday in each month. Meetings shall be held in the office of the commissioner of insurance. The members of the committee shall serve without compensation. The secretary shall be the custodian of all property, records and proceedings of the committee. Except as provided in this section and K.S.A. 74-4925, 74-4927, 75-6501 through 75-6511 and 76-749, and amendments thereto, no state agency shall purchase any insurance of any kind or nature or any surety bonds upon state officers or employees, except as provided in this act. Except as otherwise provided in this section, health care coverage and health care services of a health maintenance organization for state officers and employees designated under K.S.A. 75-6501(c), and amendments thereto, shall be provided in accordance with the provisions of K.S.A. 75-6501 through 75-6511, and amendments thereto.

(b) The Kansas turnpike authority may purchase group life, health and accident insurance or health care services of a health maintenance organization for its employees or members of the highway patrol assigned, by contract or agreement entered pursuant to K.S.A. 68-2025, and amendments thereto, to police toll or turnpike facilities, independent of the committee on surety bonds and insurance and of the provisions of K.S.A. 75-6501 through 75-6511, and amendments thereto. Such authority may purchase liability insurance covering all or any part of its operations and may purchase liability and related insurance upon all vehicles owned or operated by the authority independent of the committee on surety bonds and insurance and such

insurance may be purchased without complying with K.S.A. 75-3738 through 75-3744, and amendments thereto. Any board of county commissioners may purchase such insurance or health care services, independent of such committee, for district court officers and employees any part of whose total salary is payable by the county. Nothing in any other provision of the laws of this state shall be construed as prohibiting members of the highway patrol so assigned to police toll or turnpike facilities from receiving compensation in the form of insurance or health maintenance organization coverage as herein authorized.

(c) The agencies of the state sponsoring a foster grandparent or senior companion program, or both, shall procure a policy of accident, personal liability and excess automobile liability insurance insuring volunteers participating in such programs against loss in accordance with specifications of federal grant guidelines. Such agencies may purchase such policy of insurance independent of the committee on surety bonds and insurance and without complying with K.S.A. 75-3738 through 75-3744, and amendments thereto.

(d) Any state educational institution as defined by K.S.A. 76-711, and amendments thereto, may purchase insurance of any kind or nature except employee health insurance. Such insurance shall be purchased on a competitively bid or competitively negotiated basis in accordance with procedures prescribed by the state board of regents. Such insurance may be purchased independent of the committee on surety bonds and insurance and without complying with K.S.A. 75-3738 through 75-3744, and amendments thereto.

(e) (1) The state board of regents may enter into one or more group insurance contracts to provide health and accident insurance coverage or health care services of a health maintenance organization for all students attending a state educational institution as defined in K.S.A. 76-711, and amendments thereto, and such students' dependents, except that such insurance shall not provide coverage for elective procedures that are not medically necessary as determined by a treating physician. The participation by a student in such coverage shall be voluntary. In the case of students who are employed by a state educational institution in a student position, the level of employer contributions toward such coverage shall be determined by the board of regents.

(2) The state board of regents is hereby authorized to independently provide, through self-insurance or the purchase of insurance contracts, health care benefits for employees of a state educational institution, as such term is defined in K.S.A. 76-711, and amendments thereto, when the state health care benefits program is insufficient to satisfy the requirements of 22 C.F.R. § 62.14, as in effect upon the effective date of this section. Such healthcare benefits shall be limited to only those for whom the state health care benefits program does not meet federal requirements.

(3) The state board of regents may purchase cybersecurity insurance as it deems necessary to protect student records, labor information and other statutorily protected data that the board maintains, independent of the committee on surety bonds and insurance and without complying with the provisions of K.S.A.75-3738 through 75-3744, and amendments thereto. As used in this paragraph, "cybersecurity insurance" includes, but is not limited to, first-party coverage against losses such as data destruction, denial of service attacks, theft, hacking and liability coverage guaranteeing compensation for damages from errors such as the failure to safeguard data.

~~(3)~~*(4)* The state board of regents may adopt rules and regulations necessary to administer and implement the provisions of this section.

Sec. 19. K.S.A. 40-2209b and 40-2209e and K.S.A. 2018 Supp. 40-2209, 40-2209d, 40-2222, 40-2222a, 40-2222b and 75-4101 are hereby repealed.

Sec. 20. On and after July 1, 2019, K.S.A. 2018 Supp. 40-2222, as

amended by section 12 of this act, 40-2222a, as amended by section 14 of this act, 40-2222b, as amended by section 16 of this act, 40-2404, 40-3812, 40-3813 and 40-3814 are hereby repealed.

Sec. 21. This act shall take effect and be in force from and after its publication in the Kansas register.

I hereby certify that the above BILL originated in the HOUSE, and was adopted by that body

_____

HOUSE adopted
Conference Committee Report_____

_____
Speaker of the House.

_____
Chief Clerk of the House.

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report_____

_____
President of the Senate.

_____
Secretary of the Senate.

APPROVED _____

_____
Governor.