2021 Kansas Statutes

40-3202. Definitions. As used in this act:
(a) "Commissioner" means the commissioner of insurance of the state of Kansas.
(b) "Basic health care services" means but is not limited to usual physician, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.
(c) "Capitated basis" means a fixed per member per month payment or percentage of premium payment wherein the provider assumes risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.
(d) "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, or other entity responsible for the payment of benefits or provision of services under a group contract.
(e) "Certificate of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization, medicare provider organization or by the group contract holder.
(f) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.
(g) "Deductible" means an amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.
(h) "Director" means the secretary of health and environment.
(i) "Disability" means an injury or illness that results in a substantial physical or mental limitation in one or more major life activities such as working or independent activities of daily living that a person was able to do prior to the injury or illness.
(j) "Enrollee" means a person who has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization or the medicare provider organization for health care services.
(k) "Grievance" means a written complaint submitted in accordance with the formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization or the medicare provider organization relative to the enrollee.
(l) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.
(m) "Group contract holder" means the person to which a group contract has been issued.
(n) "Health care services" means basic health care services and other services, medical equipment and supplies which may include, but are not limited to, medical, surgical and dental care; psychological, obstetrical, osteopathic, optometric, optic, podiatric, nursing, occupational therapy services, physical therapy services, chiropractic services and pharmaceutical services; health education, preventive medical, rehabilitative and home health services; inpatient and outpatient hospital services, extended care, nursing home care, convalescent institutional care, laboratory and ambulance services, appliances, drugs, medicines and supplies; and any other care, service or treatment for the prevention, control or elimination of disease, the correction of defects or the maintenance of the physical or mental well-being of human beings.
(o) "Health maintenance organization" means an organization which:
(1) Provides or otherwise makes available to enrollees health care services, including at a minimum those basic health care services which are determined by the commissioner to be generally available on an insured or prepaid basis in the geographic area served;
(2) is compensated, except for reasonable copayments, for the provision of basic health

care services to enrollees solely on a predetermined periodic rate basis;
(3) provides physician services directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians or under arrangements as an independent contractor with a physician or any group of physicians;
(4) is responsible for the availability, accessibility and quality of the health care services provided or made available.
(p) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.
(q) "Individual practice association" means a partnership, corporation, association or other legal entity which delivers or arranges for the delivery of basic health care services and which has entered into a services arrangement with persons who are licensed to practice medicine and surgery, dentistry, chiropractic, pharmacy, podiatry, optometry or any other health profession and a majority of whom are licensed to practice medicine and surgery. Such an arrangement shall provide:
(1) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and
(2) to the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff.
(r) "Medical group" or "staff model" means a partnership, association or other group:
(1) Which is composed of health professionals licensed to practice medicine and surgery and of such other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists as are necessary for the provision of health services for which the group is responsible;
(2) a majority of the members of which are licensed to practice medicine and surgery; and
(3) the members of which: (A) As their principal professional activity over 50% individually and as a group responsibility are engaged in the coordinated practice of their profession for a health maintenance organization; (B) pool their income and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (C) share medical and other records and substantial portions of major equipment and of professional, technical and administrative staff; and (D) establish an arrangement whereby the enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee.
(s) "Medicare provider organization" means an organization which:
(1) Is a provider-sponsored organization as defined by Section 4001 of the Balanced Budget Act of 1997 (PL 105-33); and
(2) provides or otherwise makes available to enrollees basic health care services pursuant to Section 4001 of the Balanced Budget Act of 1997 (PL 105-33).
(t) "Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.
(u) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts or corporations.
(v) "Physician" means a person licensed to practice medicine and surgery under the healing arts act.
(w) "Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this state to furnish health care services.
(x) "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of

the organization's insolvency as determined by the commissioner from the latest annual statement filed pursuant to K.S.A. 40-3220 and amendments thereto and which are not guaranteed, insured or assumed by any person or organization other than the carrier.

History: L. 1974, ch. 181, § 2; L. 1975, ch. 248, § 1; L. 1984, ch. 176, § 1; L. 1996, ch. 169, § 6; L. 1998, ch. 174, § 13; L. 2000, ch. 147, § 37; July 1.