Session of 2019

Senate Substitute for HOUSE BILL No. 2143

By Committee on Financial Institutions and Insurance

3-20

AN ACT concerning healthcare benefits; relating to association health plans; non-insurance healthcare benefits coverage; jurisdiction of the commissioner; updating requirements terminology and references related thereto; amending K.S.A. 40-2209b and 40-2209e and K.S.A. 2018 Supp. 40-2209, 40-2209d, 40-2222, 40-2222a and 40-2222b and repealing the existing sections.

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

Section 1. 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 healthcare~~,~~*;* (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

1 accordance with rules and regulations adopted by the commissioner of
2 insurance; (2) any discontinued group coverage was replaced by similar
3 group coverage within 31 days; (3) the employee or member is or could be
4 covered by medicare (title XVIII of the United States social security act as
5 added by the social security amendments of 1965 or as later amended or
6 superseded); (4) the employee or member is or could be covered to the
7 same extent by any other insured or lawful self-insured arrangement which
8 provides expense incurred hospital, surgical or medical coverage and
9 benefits for individuals in a group under which the person was not covered
10 prior to such termination; or (5) coverage for the employee or member, or
11 any covered dependent thereof, was terminated for cause as permitted by
12 the group policy or certificate of coverage approved by the commissioner.
13 In the event the group policy is terminated and not replaced the insurer
14 may issue an individual policy or certificate in lieu of a conversion policy
15 or the continuation of group coverage required herein if the individual
16 policy or certificate provides substantially similar coverage for the same or
17 less premium as the group policy. In any event, the employee or member
18 shall have the option to be issued a conversion policy ~~which~~ *that* meets the
19 requirements set forth in this subsection in lieu of the right to continue
20 group coverage.
21 (j) The continued coverage and the issuance of a converted policy
22 shall be subject to the following conditions:
23 (1) Written application for the converted policy shall be made and the
24 first premium paid to the insurer not later than 31 days after termination of
25 coverage under the group policy or not later than 31 days after notice is
26 received pursuant to paragraph (20) of this subsection.
27 (2) The converted policy shall be issued without evidence of
28 insurability.
29 (3) The employer shall give the employee and such employee's
30 covered dependents reasonable notice of the right to continuation of
31 coverage. The terminated employee or member shall pay to the insurance
32 carrier the premium for the eighteen-month continuation of coverage and
33 such premium shall be the same as that applicable to members or
34 employees remaining in the group. Failure to pay such premium shall
35 terminate coverage under the group policy at the end of the period for
36 which the premium has been paid. The premium rate charged for
37 converted policies issued subsequent to the period of continued coverage
38 shall be such that can be expected to produce an anticipated loss ratio of
39 not less than 80% based upon conversion, morbidity and reasonable
40 assumptions for expected trends in medical care costs. In the event the
41 group policy is terminated and is not replaced, converted policies may be
42 issued at self-sustaining rates that are not unreasonable in relation to the
43 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 healthcare 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. 2. On and after April 1, 2019, 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. 3. On and after April 1, 2019, 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 healthcare 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

1 initial enrollment period provided under the terms of the first plan for
2 which such employee or dependent was eligible through such small
3 employer, however an eligible employee or dependent shall not be
4 considered a late enrollee if:
5 (1) The individual:
6 (A) Was covered under another employer-provided health benefit
7 plan or was covered under section 607(1) of the employee retirement
8 income security act of 1974 (ERISA) at the time the individual was
9 eligible to enroll;
10 (B) states in writing, at the time of the initial eligibility, that coverage
11 under another employer health benefit plan was the reason for declining
12 enrollment but only if the group policyholder or the accident and sickness
13 issuer required such a written statement and provided the individual with
14 notice of the requirement for a written statement and the consequences of
15 such written statement;
16 (C) has lost coverage under another employer health benefit plan or
17 under section 607(1) of the employee retirement income security act of
18 1974 (ERISA) as a result of the termination of employment, reduction in
19 the number of hours of employment, termination of employer
20 contributions toward such coverage, the termination of the other plan's
21 coverage, death of a spouse, or divorce or legal separation; and
22 (D) requests enrollment within 63 days after the termination of
23 coverage under another employer health benefit plan; or
24 (2) the individual is employed by an employer who offers multiple
25 health benefit plans and the individual elects a different health benefit plan
26 during an open enrollment period; or
27 (3) a court has ordered coverage to be provided for a spouse or minor
28 child under a covered employee's plan.
29 (r) "New business premium rate" means, for each class of business as
30 to a rating period, the lowest premium rate charged or offered, or which
31 could have been charged or offered, by the small employer carrier to small
32 employers with similar case characteristics for newly issued health benefit
33 plans with the same or similar coverage.
34 (s) "Preexisting conditions exclusion" means a policy provision
35 which excludes or limits coverage for charges or expenses incurred during
36 a specified period not to exceed 90 days following the insured's effective
37 date of enrollment as to a condition, whether physical or mental, regardless
38 of the cause of the condition for which medical advice, diagnosis, care or
39 treatment was recommended or received in the six months immediately
40 preceding the effective date of enrollment.
41 (t) "Premium" means moneys paid by a small employer or eligible
42 employees or both as a condition of receiving coverage from a small
43 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 of* 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. 4. On and after April 1, 2019, 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 healthcare 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 healthcare 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. 5. On and after April 1, 2019, 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*; or*

(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~~ 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. 6. On and after April 1, 2019, 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~~ *person or entity* 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. 7. On and after April 1, 2019, 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~~ *person or entity* 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 persons or entities that have a principal office within a*

metropolitan area that has boundaries in Kansas and persons or entities 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. 8. K.S.A. 2018 Supp. 40-2209 is hereby repealed.

Sec. 9. On and after April 1, 2019, K.S.A. 40-2209b and 40-2209e and K.S.A. 2018 Supp. 40-2209d, 40-2222, 40-2222a and 40-2222b are hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the Kansas register.