As Amended by House Committee

Session of 2004

SENATE BILL No. 340

By Committee on Financial Institutions and Insurance

1-22

AN ACT concerning insurance; relating to risk-based capital requirements; **relating to the Kansas uninsurable health insurance plan;** amending **K.S.A. 40-2118, 40-2122 and 40-2124 and** K.S.A. 2003 Supp. 40-2c01 and repealing the existing section.

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

Section 1. **From and after July 1, 2004,** K.S.A. 2003 Supp. 40-2c01 is hereby amended to read as follows: 40-2c01. As used in this act:

(a) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with K.S.A. 40-2c04, and amendments thereto.

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required to address a RBC level event.

(c) "Domestic insurer" means any insurance company or risk retention group which is licensed and organized in this state.

(d) "Foreign insurer" means any insurance company or risk retention group not domiciled in this state which is licensed or registered to do business in this state pursuant to article 41 of chapter 40 of the Kansas Statutes Annotated or K.S.A. 40-209, and amendments thereto.

(e) "NAIC" means the national association of insurance commissioners.

(f) "Life and health insurer" means any insurance company licensed under article 4 or 5 of chapter 40 of the Kansas Statutes Annotated or a licensed property and casualty insurer writing only accident and health insurance.

(g) "Property and casualty insurer" means any insurance company licensed under articles 9, 10, 11, 12, 12a, 15 or 16 of chapter 40 of the Kansas Statutes Annotated, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) "Negative trend" means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the RBC instructions defined in subsection (j).

(i) "RBC" means risk-based capital.

(j) "RBC instructions" mean the risk-based capital instructions promulgated by the NAIC, which are in effect on December 31, ~~2002~~ *2003*.

(k) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(2) "regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(3) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) "mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(l) "RBC plan" means a comprehensive financial plan containing the elements specified in K.S.A. 40-2c06, and amendments thereto. If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(m) "RBC report" means the report required by K.S.A. 40-2c02, and amendments thereto.

(n) "Total adjusted capital" means the sum of:

(1) An insurer's capital and surplus or surplus only if a mutual insurer; and

(2) such other items, if any, as the RBC instructions may provide.

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

~~Sec. 2. K.S.A. 2003 Supp. 40-2c01 is hereby repealed.~~

~~Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.~~ **Sec. 2. K.S.A. 40-2118 is hereby amended to read as follows: 40-2118. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:**

(a) "Administering carrier" means the insurer or third-party administrator designated in K.S.A. 40-2120, and amendments thereto.

(b) "Association" means the Kansas health insurance association established in K.S.A. 40-2119, and amendments thereto.

(c) "Board" means the board of directors of the association.

(d) "Church plan" means a plan as defined under section 3(33) of the Employee Retirement Income Security Act of 1974.

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

(f) "Creditable coverage" means with respect to an individual,

coverage of the individual under any of the following:

(1) A group health plan~~.~~*;*

(2) health insurance coverage;

(3) part A or Part B of Title XVIII of the Social Security Act;

(4) title XIX of the Social Security Act, other than coverage consisting solely of benefit under Section 1928;

(5) chapter 55 of Title 10, United States Code;

(6) a medical care program of the Indian Health Service or of a tribal organization;

(7) a state health benefit risk pool;

(8) a health plan offered under Chapter 89 of Title 5, United States Code;

(9) a public health plan as defined under regulations promulgated by the secretary of health and human services; and

(10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d)).

(g) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 23 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(h) ~~"Federally defined eligible individual" means an individual:~~

~~(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more months and whose most recent prior coverage was under a group health plan, government plan or church plan;~~

~~(2) who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;~~

~~(3) with respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and~~

~~(4) who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.~~

~~(i)~~ "Excess loss" means the total dollar amount by which claims expense incurred for any issuer of a medicare supplement policy or certificate delivered or issued for delivery to persons in this state eligible for medicare by reason of disability and who are under age 65 exceeds 65% of the premium earned by such issuer during a calendar year.

(i) "Federally defined eligible individual" means an individual:

(1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more

months and whose most recent prior coverage was under a group health plan, government plan or church plan;

(2) who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(3) with respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(4) who had been offered the option of continuation coverage under COBRA or under a similar program, who elected such continuation coverage, and who has exhausted such continuation coverage.

(j) "Federally defined eligible individuals for FTAA" means an individual who is:

(1) Legally domiciled in this state; and

(2) eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986.

~~(j)~~ *(k) "FTAA" means federal trade adjustment assistance under the federal trade adjustment assistance reform act of 2002, public law 107-210.*

(l) **"Governmental plan" means a plan as defined under section 3(32) of the Employee Retirement Income Security Act of 1974 and any plan maintained for its employees by the government of the United States or by any agency or instrumentality of such government.**

~~(k)~~ *(m)* **"Group health plan" means an employee benefit plan as defined by section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides any hospital, surgical or medical expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.**

~~(l)~~ *(n)* **"Health insurance" 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 insurance" 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 pol-**

icy or equivalent self-insurance.

~~(m)~~ *(o)* **"Health maintenance organization" means any organization granted a certificate of authority under the provisions of the health maintenance organization act.**

~~(n)~~ *(p)* **"Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a group-funded pool, trust or third-party administrator, health care services or benefits other than through an insurer.**

~~(o)~~ *(q)* **"Insurer" means any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance business in this state.**

~~(p)~~ *(r)* **"Medicaid" means the medical assistance program operated by the state under title XIX of the federal social security act.**

~~(q)~~ *(s)* **"Medicare" means coverage under both parts A and B of title XVIII of the federal social security act, 42 USC 1395.**

~~(r)~~ *(t)* **"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospitals and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 USC 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.**

~~(s)~~ *(u)* **"Member" means all insurers and insurance arrangements participating in the association.**

~~(t)~~ *(v)* **"Plan" means the Kansas uninsurable health insurance plan created pursuant to this act.**

~~(u)~~ *(w)* **"Plan of operation" means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, bylaws and operating rules, adopted by the board pursuant to K.S.A. 40-2119, and amendments thereto.**

Sec. 3. K.S.A. 40-2122 is hereby amended to read as follows: 40-2122. (a) The following individuals shall be eligible for plan coverage provided they meet the criteria set forth in subsection (b):

(1) Any person who has been a resident of this state for at least six months;

(2) any person who is a legal domiciliary of this state who previously was covered under the high risk pool of another state, provided they apply for coverage under the plan within 63 days of losing such other coverage for reasons other than fraud or nonpayment of premiums; ~~or~~

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

*(4) any federally defined eligible individual for FTAA***.**

(b) Those individuals who are eligible for plan coverage under subsection (a) must provide evidence satisfactory to the administering carrier that such person meets one of the following criteria:

(1) Such person has had health insurance coverage involuntarily terminated for any reason other than nonpayment of premium;

(2) such person has applied for health insurance and been rejected by two carriers because of health conditions;

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

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

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

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

(c) Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

(d) The following persons shall not be eligible for coverage under the plan:

(1) Any person who is eligible for medicare or is eligible for medicaid benefits;

(2) any person who has had coverage under the plan terminated less than 12 months prior to the date of the current application, except that this provision shall not apply with respect to an applicant who is a federally defined eligible individual;

(3) any person who has received accumulated benefits from the plan equal to or in excess of the lifetime maximum benefits under the plan prescribed by K.S.A. 40-2124 and amendments thereto;

(4) any person having access to accident and health insurance through an employer-sponsored group or self-insured plan*, including coverage under the consolidated omnibus budget reconciliation act (COBRA), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person:*

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

(B) has three months of prior creditable coverage as described in sub-

section (c) of K.S.A. 40-2124, and amendments thereto; **or**

(5) any person who is eligible for any other public or private program that provides or indemnifies for health services.

(e) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of a policy period.

(f) All plan members, insurers and insurance arrangements shall notify in writing persons denied health insurance coverage, for any reason, of the availability of coverage through the Kansas health insurance association.

Sec. 4. K.S.A. 40-2124 is hereby amended to read as follows: 40-2124. (a) Coverage under the plan shall be subject to both deductible and coinsurance provisions set by the board. On and after January 1, 1998, the plan shall offer to current participants and new enrollees no fewer than four choices of deductible and copayment options. Coverage shall contain a coinsurance provision for each service covered by the plan, and such copayment requirement shall not be subject to a stop-loss provision. Such coverage may provide for a percentage or dollar amount of coinsurance reduction at specific thresholds of copayment expenditures by the insured.

(b) Coverage under the plan shall be subject to a maximum lifetime benefit of $1,000,000 per covered individual.

(c) On and after May 1, 1994, coverage under the plan shall exclude charges or expenses incurred during the first 90 days following the effective date of coverage as to any condition: (1) Which manifested itself during the six-month period immediately prior to the application for coverage in such manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or (2) for which medical advice, care or treatment was recommended or received in the six-month period immediately prior to the application for coverage. In succeeding years of operation of the plan, coverage of preexisting conditions may be excluded as determined by the board, except that no such exclusion shall exceed 180 calendar days, and no exclusion shall be applied to a federally defined eligible individual provided that application for coverage is made not later than 63 days following the applicant's most recent prior creditable coverage. *For any individual who is eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986, the preexisting conditions limitation will not apply whenever such individual has maintained creditable health insurance coverage for an aggregate period of three months, not counting any period prior to a 63 day break in coverage, as of the date on which such individual seeks to enroll in coverage provided by this act.*

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

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

Sec. 5. K.S.A. 40-2118, 40-2122 and 40-2124 are hereby repealed.

Sec. 6. From and after July 1, 2004, K.S.A. 2003 Supp. 40-2c01 is hereby repealed.

Sec. 7. This act shall take effect and be in force from and after its publication in the Kansas register.