Session of 2008

HOUSE BILL No. 2934

By Committee on Appropriations

2-22

AN ACT enacting the health care reform act of 2008; amending K.S.A. 21-3851, 40-2119, 40-2124, 40-2209d, 40-2209m and K.S.A. 2007 Supp. 39-709, 40-19c06, 40-2209, 40-2240, 40-3209, 65-7402, 65-7403, 75-6501, 75-7423, 75-7427 and 79-32,117 and repealing the existing sections.

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

New Section 1. (a) An employer that provides a health insurance plan for which any portion of the premium is payable by the employer shall offer to establish a premium only cafeteria plan as permitted under federal law, 26 U.S.C. Section 125. The provisions of this subsection shall not apply to employers who offer health insurance through any self-insured or self-funded group health benefit plan of any type or description.

(b) Nothing in this section shall prohibit or otherwise restrict an employer's ability to either provide a group health benefit plan or create a premium only cafeteria plan with defined contributions and in which the employee purchases the policy.

(c) As used in this section "health insurance 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.

New Sec. 2. (a) An insurer shall provide, in conjunction with an individual or group health benefit plan, the option of establishing a cafeteria plan as permitted under federal law, 26 U.S.C. section 125.

(b) As used in this section "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.

New Sec. 3. The legislative coordinating council shall appoint a legislative study committee during the 2008 interim period to study and review the establishment of an individual and small employer reinsurance program, review the role of the high risk insurance pool and make recommendations concerning modernization of the medicaid and the state children's health insurance program.

New Sec. 4. (a) An employer that provides health insurance coverage for which any portion of the premium is payable by such employer shall not provide such coverage unless the employer has established a premium only cafeteria plan as permitted under 26 U.S.C. Section 125. The provisions of this subsection shall not apply to any employer who offers health insurance through any self-insured or self-funded group health benefit plan of any type or description.

(b) No provision of this section shall prohibit or otherwise restrict an employer's ability to either provide a group health benefit plan or create a premium only cafeteria plan with defined contributions and in which the employee purchases the policy.

(c) For the purposes of this section:

(1) "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. The cafeteria plan may offer the option paying all or any portion of the health insurance premium or 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. "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.

(2) "Health savings account" shall have the same meaning ascribed to it as in subsection (d) of 26 U.S.C. Section 223.

(3) "High deductible health plan" shall mean 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 and any amendments and regulations.

New Sec. 5. (a) A credit against the taxes otherwise due under the Kansas income tax act shall be allowed to an individual for amounts paid during the taxable year for purposes of providing health insurance or care in the form of a health benefit plan and amounts contributed to a health

savings account of such individual.

(b) For any individual that has established a health benefit plan after December 31, 2008, the amount of the credit allowed by subsection (a) shall be $35 per month or 50% of the total amount paid by the individual toward the health benefit plan during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75% of the lesser of $35 per month or 50% of the total amount paid by the individual toward the health benefit plan during the taxable year. In the fourth year, the credit shall be equal to 50% of the lesser of $35 per month paid by the individual toward the health benefit plan or 50% of the total amount paid by the individual toward the health benefit plan during the taxable year. In the fifth year, the credit shall be equal to 25% of the lesser of $35 per month paid by the individual toward the health benefit plan or 50% of the total amount paid by the individual toward the health benefit plan during the taxable year. For the sixth and subsequent years, no credit shall be allowed.

(c) If the credit allowed by this section is claimed, the amount of any deduction allowable under the Kansas income tax act for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with law. If the credit allowed by this section exceeds the taxes imposed under the Kansas income tax act for the taxable year, that portion of the credit which exceeds those taxes shall be refunded to the taxpayer.

(d) The secretary of revenue shall promulgate rules and regulations to carry out the provisions of this section.

(e) For the purposes of this section:

(1) "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. The cafeteria plan may offer the option paying all or any portion of the health insurance premium or 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. "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.

(2) "Health savings account" shall have the same meaning ascribed to it as in subsection (d) of 26 U.S.C. Section 223.

(3) "High deductible health plan" shall mean 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 and any amendments and regulations.

(4) "Individual" means a self employed individual or an individual who purchases health insurance coverage through a health benefit plan which is not provided by such individual's employer.

New Sec. 6. (a) (1) Beginning with the open enrollment period for the 2009 plan year, the administering carrier shall offer to all eligible individuals the option of receiving health care coverage through a high deductible health plan and the establishment of a health savings account. Such option may be offered through a cafeteria plan authorized by 26 U.S.C. Section 125.

(2) The administering carrier shall issue a request for proposals from companies interested in offering a high deductible health plan in connection with a health savings account.

(b) For the purposes of this section, the term:

(1) "Administering carrier" shall have the meaning ascribed to it in K.S.A. 40-2122 and amendments thereto.

(2) "Health savings account" shall have the meaning ascribed to it as in subsection (d) of 26 U.S.C. Section 223.

(3) "High deductible health plan" shall mean 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 and any regulations promulgated thereunder.

(c) This section shall be part of and supplemental to the Kansas uninsurable health insurance plan act.

Sec. 7. K.S.A. 21-3851 is hereby amended to read as follows: 21-3851. (a) Any person convicted of a violation of this act, may be liable, in addition to any other criminal penalties provided by law, for all of the following:

(1) Payment of full restitution of the amount of the excess payments;

(2) payment of interest on the amount of any excess payments at the maximum legal rate in effect on the date the payment was made to the person for the period from the date upon which payment was made, to the date upon which repayment is made;

(3) payment of all reasonable expenses that have been necessarily incurred in the enforcement of this act, including, but not limited to, the costs of the investigation, litigation and attorney fees.

(b) All moneys recovered pursuant to subsection (a)(1) and (2), shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the medicaid fraud reimbursement fund, which is hereby established in the state treasury. Moneys in the medicaid fraud reimbursement fund shall be divided and payments made from such fund to the federal government and affected state agencies for the refund of moneys falsely obtained from the federal and state governments.

(c) All moneys recovered pursuant to subsection (a)(3) shall be remitted to the state treasurer in accordance with the provisions of K.S.A. 75-4215, and amendments thereto. Upon receipt of each such remittance, the state treasurer shall deposit the entire amount in the state treasury to the credit of the medicaid fraud prosecution revolving fund, which is hereby established in the state treasury. *Except as provided in subsection (d),* moneys in the medicaid fraud prosecution revolving fund may be appropriated to the attorney general, or to any county or district attorney who has successfully prosecuted an action for a violation of this act and been awarded such costs of prosecution, in order to defray the costs of the attorney general and any such county or district attorney in connection with their duties provided by this act. No moneys shall be paid into the medicaid fraud prosecution revolving fund pursuant to this section unless the attorney general or appropriate county or district attorney has commenced a prosecution pursuant to this section, and the court finds in its discretion that payment of attorney fees and investigative costs is appropriate under all the circumstances, and the attorney general, or county or district attorney has proven to the court that the expenses were reasonable and necessary to the investigation and prosecution of such case, and the court approves such expenses as being reasonable and necessary.

(d) If the attorney general determines that information discovered by and received from the inspector general was responsible for uncovering the medicaid fraud, 50% of the moneys recovered from persons committing such fraud shall be appropriated to the office of the inspector general in order to assist in defraying the costs of operation of the office of inspector general. The money appropriated to the office of inspector general under this subsection shall not exceed a total of $2,000,000 for the period ending with fiscal year 2013.

Sec. 8. K.S.A. 2007 Supp. 39-709 is hereby amended to read as follows: 39-709. (a) *General eligibility requirements for assistance for which federal moneys are expended.* Subject to the additional requirements be-

low, assistance in accordance with plans under which federal moneys are expended may be granted to any needy person who:

(1) Has insufficient income or resources to provide a reasonable subsistence compatible with decency and health. Where a husband and wife are living together, the combined income or resources of both shall be considered in determining the eligibility of either or both for such assistance unless otherwise prohibited by law. The secretary, in determining need of any applicant for or recipient of assistance shall not take into account the financial responsibility of any individual for any applicant or recipient of assistance unless such applicant or recipient is such individual's spouse or such individual's minor child or minor stepchild if the stepchild is living with such individual. The secretary in determining need of an individual may provide such income and resource exemptions as may be permitted by federal law. For purposes of eligibility for aid for families with dependent children, for food stamp assistance and for any other assistance provided through the department of social and rehabilitation services under which federal moneys are expended, the secretary of social and rehabilitation services shall consider one motor vehicle owned by the applicant for assistance, regardless of the value of such vehicle, as exempt personal property and shall consider any equity in any additional motor vehicle owned by the applicant for assistance to be a nonexempt resource of the applicant for assistance.

(2) Is a citizen of the United States or is an alien lawfully admitted to the United States and who is residing in the state of Kansas.

(b) *Assistance to families with dependent children.* Assistance may be granted under this act to any dependent child, or relative, subject to the general eligibility requirements as set out in subsection (a), who resides in the state of Kansas or whose parent or other relative with whom the child is living resides in the state of Kansas. Such assistance shall be known as aid to families with dependent children. Where husband and wife are living together both shall register for work under the program requirements for aid to families with dependent children in accordance with criteria and guidelines prescribed by rules and regulations of the secretary.

(c) *Aid to families with dependent children; assignment of support rights and limited power of attorney.* By applying for or receiving aid to families with dependent children such applicant or recipient shall be deemed to have assigned to the secretary on behalf of the state any accrued, present or future rights to support from any other person such applicant may have in such person's own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid. In any case in which an order for child support has been established and the legal custodian and obligee under the order surrenders physical cus-

tody of the child to a caretaker relative without obtaining a modification of legal custody and support rights on behalf of the child are assigned pursuant to this section, the surrender of physical custody and the assignment shall transfer, by operation of law, the child's support rights under the order to the secretary on behalf of the state. Such assignment shall be of all accrued, present or future rights to support of the child surrendered to the caretaker relative. The assignment of support rights shall automatically become effective upon the date of approval for or receipt of such aid without the requirement that any document be signed by the applicant, recipient or obligee. By applying for or receiving aid to families with dependent children, or by surrendering physical custody of a child to a caretaker relative who is an applicant or recipient of such assistance on the child's behalf, the applicant, recipient or obligee is also deemed to have appointed the secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary in behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the secretary approves the application for aid and shall remain in effect until the assignment of support rights has been terminated in full.

(d) *Eligibility requirements for general assistance, the cost of which is not shared by the federal government.* (1) General assistance may be granted to eligible persons who do not qualify for financial assistance in a program in which the federal government participates and who satisfy the additional requirements prescribed by or under this subsection (d).

(A) To qualify for general assistance in any form a needy person must have insufficient income or resources to provide a reasonable subsistence compatible with decency and health and, except as provided for transitional assistance, be a member of a family in which a minor child or a pregnant woman resides or be unable to engage in employment. The secretary shall adopt rules and regulations prescribing criteria for establishing when a minor child may be considered to be living with a family and whether a person is able to engage in employment, including such factors as age or physical or mental condition. Eligibility for general assistance, other than transitional assistance, is limited to families in which a minor child or a pregnant woman resides or to an adult or family in which all legally responsible family members are unable to engage in employment. Where a husband and wife are living together the combined income or resources of both shall be considered in determining the eligibility of either or both for such assistance unless otherwise prohibited by law. The secretary in determining need of any applicant for or recipient of general assistance shall not take into account the financial responsibility

of any individual for any applicant or recipient of general assistance unless such applicant or recipient is such individual's spouse or such individual's minor child or a minor stepchild if the stepchild is living with such individual. In determining the need of an individual, the secretary may provide for income and resource exemptions.

(B) To qualify for general assistance in any form a needy person must be a citizen of the United States or an alien lawfully admitted to the United States and must be residing in the state of Kansas.

(2) General assistance in the form of transitional assistance may be granted to eligible persons who do not qualify for financial assistance in a program in which the federal government participates and who satisfy the additional requirements prescribed by or under this subsection (d), but who do not meet the criteria prescribed by rules and regulations of the secretary relating to inability to engage in employment or are not a member of a family in which a minor or a pregnant woman resides.

(3) In addition to the other requirements prescribed under this subsection (d), the secretary shall adopt rules and regulations which establish community work experience program requirements for eligibility for the receipt of general assistance in any form and which establish penalties to be imposed when a work assignment under a community work experience program requirement is not completed without good cause. The secretary may adopt rules and regulations establishing exemptions from any such community work experience program requirements. A first time failure to complete such a work assignment requirement shall result in ineligibility to receive general assistance for a period fixed by such rules and regulations of not more than three calendar months. A subsequent failure to complete such a work assignment requirement shall result in a period fixed by such rules and regulations of ineligibility of not more than six calendar months.

(4) If any person is found guilty of the crime of theft under the provisions of K.S.A. 39-720, and amendments thereto, such person shall thereby become forever ineligible to receive any form of general assistance under the provisions of this subsection (d) unless the conviction is the person's first conviction under the provisions of K.S.A. 39-720, and amendments thereto, or the law of any other state concerning welfare fraud. First time offenders convicted of a misdemeanor under the provisions of such statute shall become ineligible to receive any form of general assistance for a period of 12 calendar months from the date of conviction. First time offenders convicted of a felony under the provisions of such statute shall become ineligible to receive any form of general assistance for a period of 60 calendar months from the date of conviction. If any person is found guilty by a court of competent jurisdiction of any state other than the state of Kansas of a crime involving welfare fraud,

such person shall thereby become forever ineligible to receive any form of general assistance under the provisions of this subsection (d) unless the conviction is the person's first conviction under the law of any other state concerning welfare fraud. First time offenders convicted of a misdemeanor under the law of any other state concerning welfare fraud shall become ineligible to receive any form of general assistance for a period of 12 calendar months from the date of conviction. First time offenders convicted of a felony under the law of any other state concerning welfare fraud shall become ineligible to receive any form of general assistance for a period of 60 calendar months from the date of conviction.

(e) *Requirements for medical assistance for which federal moneys or state moneys or both are expended.* (1) When the secretary has adopted a medical care plan under which federal moneys or state moneys or both are expended, medical assistance in accordance with such plan shall be granted to any person *less than 18 years of age* who is a citizen of the United States or who is an alien lawfully admitted to the United States and who is residing in the state of Kansas *or any person 18 years of age or older who is a citizen of the United States*, whose resources and income do not exceed the levels prescribed by the secretary. In determining the need of an individual, the secretary may provide for income and resource exemptions and protected income and resource levels. Resources from inheritance shall be counted. A disclaimer of an inheritance pursuant to K.S.A. 59-2291, and amendments thereto, shall constitute a transfer of resources. The secretary shall exempt principal and interest held in irrevocable trust pursuant to subsection (c) of K.S.A. 16-303, and amendments thereto, from the eligibility requirements of applicants for and recipients of medical assistance. Such assistance shall be known as medical assistance.

(2) For the purposes of medical assistance eligibility determinations on or after July 1, 2004, if an applicant or recipient owns property in joint tenancy with some other party and the applicant or recipient of medical assistance has restricted or conditioned their interest in such property to a specific and discrete property interest less than 100%, then such designation will cause the full value of the property to be considered an available resource to the applicant or recipient.

(3) Resources from trusts shall be considered when determining eligibility of a trust beneficiary for medical assistance. Medical assistance is to be secondary to all resources, including trusts, that may be available to an applicant or recipient of medical assistance. If a trust has discretionary language, the trust shall be considered to be an available resource to the extent, using the full extent of discretion, the trustee may make any of the income or principal available to the applicant or recipient of medical assistance. Any such discretionary trust shall be considered an

available resource unless: (1) The trust is funded exclusively from resources of a person who, at the time of creation of the trust, owed no duty of support to the applicant or recipient; and (2) the trust contains specific contemporaneous language that states an intent that the trust be supplemental to public assistance and the trust makes specific reference to medicaid, medical assistance or title XIX of the social security act.

(4) (A) When an applicant or recipient of medical assistance is a party to a contract, agreement or accord for personal services being provided by a nonlicensed individual or provider and such contract, agreement or accord involves health and welfare monitoring, pharmacy assistance, case management, communication with medical, health or other professionals, or other activities related to home health care, long term care, medical assistance benefits, or other related issues, any moneys paid under such contract, agreement or accord shall be considered to be an available resource unless the following restrictions are met: (i) The contract, agreement or accord must be in writing and executed prior to any services being provided; (ii) the moneys paid are in direct relationship with the fair market value of such services being provided by similarly situated and trained nonlicensed individuals; (iii) if no similarly situated nonlicensed individuals or situations can be found, the value of services will be based on federal hourly minimum wage standards; (iv) such individual providing the services will report all receipts of moneys as income to the appropriate state and federal governmental revenue agencies; (v) any amounts due under such contract, agreement or accord shall be paid after the services are rendered; (vi) the applicant or recipient shall have the power to revoke the contract, agreement or accord; and (vii) upon the death of the applicant or recipient, the contract, agreement or accord ceases.

(B) When an applicant or recipient of medical assistance is a party to a written contract for personal services being provided by a licensed health professional or facility and such contract involves health and welfare monitoring, pharmacy assistance, case management, communication with medical, health or other professionals, or other activities related to home health care, long term care, medical assistance benefits or other related issues, any moneys paid in advance of receipt of services for such contracts shall be considered to be an available resource.

(5) Medical assistance recipients, as a condition for further eligibility, shall participate in a wellness program designed to assist those recipients who smoke to quit smoking, to assist recipients who are obese to lose weight or to assist recipients who abuse drugs to cease this abuse, or to assist recipients with any combination of these. On and after July 1, 2009, a recipient must show progress in these health areas and must annually have a doctor's certificate that progress is being made. If a doctor certifies after two years that progress has not been made by the recipient on any

one of the wellness program activities enumerated in this paragraph, then the recipient shall receive medical assistance which provides only the minimum federal assistance authorized by law. If the recipient one year later is certified as showing progress in the wellness activity or activities applicable to the recipient then the recipient shall be restored to full medical benefits. If three years after the recipient commences the wellness program the recipient is certified by a doctor as not showing progress on any of the wellness activities applicable to the recipient, the recipient shall be terminated from the medicaid program.

(6) Medical assistance recipients whose coverage has been terminated but who still meet the other requirements of this section, may purchase a health care benefits plan which provides coverage at least equal to the federal medicaid basic coverage plan. The commissioner of insurance may waive any rule and regulation or waive any mandated coverage otherwise required by state law for such plan. Such coverage shall be available for a period of three years from the date the state medical assistance ends and shall be underwritten by the appropriate underwriter on a market basis.

(f) *Eligibility for medical assistance of resident receiving medical care outside state.* A person who is receiving medical care including long-term care outside of Kansas whose health would be endangered by the postponement of medical care until return to the state or by travel to return to Kansas, may be determined eligible for medical assistance if such individual is a resident of Kansas and all other eligibility factors are met. Persons who are receiving medical care on an ongoing basis in a long-term medical care facility in a state other than Kansas and who do not return to a care facility in Kansas when they are able to do so, shall no longer be eligible to receive assistance in Kansas unless such medical care is not available in a comparable facility or program providing such medical care in Kansas. For persons who are minors or who are under guardianship, the actions of the parent or guardian shall be deemed to be the actions of the child or ward in determining whether or not the person is remaining outside the state voluntarily.

(g) *Medical assistance; assignment of rights to medical support and limited power of attorney; recovery from estates of deceased recipients.* (1) Except as otherwise provided in K.S.A. 39-786 and 39-787, and amendments thereto, or as otherwise authorized on and after September 30, 1989, under section 303 and amendments thereto of the federal medicare catastrophic coverage act of 1988, whichever is applicable, by applying for or receiving medical assistance under a medical care plan in which federal funds are expended, any accrued, present or future rights to support and any rights to payment for medical care from a third party of an applicant or recipient and any other family member for whom the

applicant is applying shall be deemed to have been assigned to the secretary on behalf of the state. The assignment shall automatically become effective upon the date of approval for such assistance without the requirement that any document be signed by the applicant or recipient. By applying for or receiving medical assistance the applicant or recipient is also deemed to have appointed the secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments, representing payments received by the secretary in behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the secretary approves the application for assistance and shall remain in effect until the assignment has been terminated in full. The assignment of any rights to payment for medical care from a third party under this subsection shall not prohibit a health care provider from directly billing an insurance carrier for services rendered if the provider has not submitted a claim covering such services to the secretary for payment. Support amounts collected on behalf of persons whose rights to support are assigned to the secretary only under this subsection and no other shall be distributed pursuant to subsection (d) of K.S.A. 39-756, and amendments thereto, except that any amounts designated as medical support shall be retained by the secretary for repayment of the unreimbursed portion of assistance. Amounts collected pursuant to the assignment of rights to payment for medical care from a third party shall also be retained by the secretary for repayment of the unreimbursed portion of assistance.

(2) The amount of any medical assistance paid after June 30, 1992, under the provisions of subsection (e) is (A) a claim against the property or any interest therein belonging to and a part of the estate of any deceased recipient or, if there is no estate, the estate of the surviving spouse, if any, shall be charged for such medical assistance paid to either or both, and (B) a claim against any funds of such recipient or spouse in any account under K.S.A. 9-1215, 9-1216, 17-2263, 17-2264, 17-5828 or 17-5829, and amendments thereto. There shall be no recovery of medical assistance correctly paid to or on behalf of an individual under subsection (e) except after the death of the surviving spouse of the individual, if any, and only at a time when the individual has no surviving child who is under 21 years of age or is blind or permanently and totally disabled. Transfers of real or personal property by recipients of medical assistance without adequate consideration are voidable and may be set aside. Except where there is a surviving spouse, or a surviving child who is under 21 years of age or is blind or permanently and totally disabled, the amount of any medical assistance paid under subsection (e) is a claim against the estate in any guardianship or conservatorship proceeding. The monetary value

of any benefits received by the recipient of such medical assistance under long-term care insurance, as defined by K.S.A. 40-2227, and amendments thereto, shall be a credit against the amount of the claim provided for such medical assistance under this subsection (g). The secretary is authorized to enforce each claim provided for under this subsection (g). The secretary shall not be required to pursue every claim, but is granted discretion to determine which claims to pursue. All moneys received by the secretary from claims under this subsection (g) shall be deposited in the social welfare fund. The secretary may adopt rules and regulations for the implementation and administration of the medical assistance recovery program under this subsection (g).

(3) By applying for or receiving medical assistance under the provisions of article 7 of chapter 39 of the Kansas Statutes Annotated, such individual or such individual's agent, fiduciary, guardian, conservator, representative payee or other person acting on behalf of the individual consents to the following definitions of estate and the results therefrom:

(A) If an individual receives any medical assistance before July 1, 2004, pursuant to article 7 of chapter 39 of the Kansas Statutes Annotated, which forms the basis for a claim under subsection (g)(2), such claim is limited to the individual's probatable estate as defined by applicable law; and

(B) if an individual receives any medical assistance on or after July 1, 2004, pursuant to article 7 of chapter 39 of the Kansas Statutes Annotated, which forms the basis for a claim under subsection (g)(2), such claim shall apply to the individual's medical assistance estate. The medical assistance estate is defined as including all real and personal property and other assets in which the deceased individual had any legal title or interest immediately before or at the time of death to the extent of that interest or title. The medical assistance estate includes, without limitation assets conveyed to a survivor, heir or assign of the deceased recipient through joint tenancy, tenancy in common, survivorship, transfer-on-death deed, payable-on-death contract, life estate, trust, annuities or similar arrangement.

(4) The secretary of social and rehabilitation services or the secretary's designee is authorized to file and enforce a lien against the real property of a recipient of medical assistance in certain situations, subject to all prior liens of record. The lien must be filed in the office of the register of deeds of the county where the real property is located and must contain the legal description of all real property in the county subject to the lien. This lien is for payments of medical assistance made by the department of social and rehabilitation services to the recipient who is an inpatient in a nursing home or other medical institution. Such lien may be filed only after notice and an opportunity for a hearing has been given.

Such lien may be enforced only upon competent medical testimony that the recipient cannot reasonably be expected to be discharged and returned home. A six-month period of compensated inpatient care at a nursing home, nursing homes or other medical institution shall constitute a determination by the department of social and rehabilitation services that the recipient cannot reasonably be expected to be discharged and returned home. To return home means the recipient leaves the nursing or medical facility and resides in the home on which the lien has been placed for a period of at least 90 days without being readmitted as an inpatient to a nursing or medical facility. The amount of the lien shall be for the amount of assistance paid by the department of social and rehabilitation services after the expiration of six months from the date the recipient became eligible for compensated inpatient care at a nursing home, nursing homes or other medical institution until the time of the filing of the lien and for any amount paid thereafter for such medical assistance to the recipient.

(5) The lien filed by the secretary or the secretary's designee for medical assistance correctly received may be enforced before or after the death of the recipient by the filing of an action to foreclose such lien in the Kansas district court or through an estate probate court action in the county where the real property of the recipient is located. However, it may be enforced only:

(A) After the death of the surviving spouse of the recipient;

(B) when there is no child of the recipient, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the recipient, natural or adopted, who is blind or disabled residing in the home; or

(D) when no brother or sister of the recipient is lawfully residing in the home, who has resided there for at least one year immediately before the date of the recipient's admission to the nursing or medical facility, and has resided there on a continuous basis since that time.

(6) The lien remains on the property even after a transfer of the title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The recipient, the heirs, personal representative or assigns of the recipient may discharge such lien at any time by paying the amount of the lien to the secretary or the secretary's designee;

(B) the lien is terminated by foreclosure of prior lien of record or settlement action taken in lieu of foreclosure;

(C) the value of the real property is consumed by the lien, at which time the secretary or the secretary's designee may force the sale for the real property to satisfy the lien; or

(D) after a lien is filed against the real property, it will be dissolved

if the recipient leaves the nursing or medical facility and resides in the property to which the lien is attached for a period of more than 90 days without being readmitted as an inpatient to a nursing or medical facility, even though there may have been no reasonable expectation that this would occur. If the recipient is readmitted to a nursing or medical facility during this period, and does return home after being released, another 90 days must be completed before the lien can be dissolved.

(7) If the secretary of social and rehabilitation services or the secretary's designee has not filed an action to foreclose the lien in the Kansas district court in the county where the real property is located within 10 years from the date of the filing of the lien, then the lien shall become dormant, and shall cease to operate as a lien on the real estate of the recipient. Such dormant lien may be revived in the same manner as a dormant judgment lien is revived under K.S.A. 60-2403 et seq., and amendments thereto.

(h) *Placement under the revised Kansas code for care of children or revised Kansas juvenile justice code; assignment of support rights and limited power of attorney.* In any case in which the secretary of social and rehabilitation services pays for the expenses of care and custody of a child pursuant to K.S.A. 2007 Supp. 38-2201 et seq. or 38-2301 et seq., and amendments thereto, including the expenses of any foster care placement, an assignment of all past, present and future support rights of the child in custody possessed by either parent or other person entitled to receive support payments for the child is, by operation of law, conveyed to the secretary. Such assignment shall become effective upon placement of a child in the custody of the secretary or upon payment of the expenses of care and custody of a child by the secretary without the requirement that any document be signed by the parent or other person entitled to receive support payments for the child. When the secretary pays for the expenses of care and custody of a child or a child is placed in the custody of the secretary, the parent or other person entitled to receive support payments for the child is also deemed to have appointed the secretary, or the secretary's designee, as attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary on behalf of the child. This limited power of attorney shall be effective from the date the assignment to support rights becomes effective and shall remain in effect until the assignment of support rights has been terminated in full.

(i) No person who voluntarily quits employment or who is fired from employment due to gross misconduct as defined by rules and regulations of the secretary or who is a fugitive from justice by reason of a felony conviction or charge shall be eligible to receive public assistance benefits

in this state. Any recipient of public assistance who fails to timely comply with monthly reporting requirements under criteria and guidelines prescribed by rules and regulations of the secretary shall be subject to a penalty established by the secretary by rules and regulations.

(j) If the applicant or recipient of aid to families with dependent children is a mother of the dependent child, as a condition of the mother's eligibility for aid to families with dependent children the mother shall identify by name and, if known, by current address the father of the dependent child except that the secretary may adopt by rules and regulations exceptions to this requirement in cases of undue hardship. Any recipient of aid to families with dependent children who fails to cooperate with requirements relating to child support enforcement under criteria and guidelines prescribed by rules and regulations of the secretary shall be subject to a penalty established by the secretary by rules and regulations which penalty shall progress to ineligibility for the family after three months of noncooperation.

(k) By applying for or receiving child care benefits or food stamps, the applicant or recipient shall be deemed to have assigned, pursuant to K.S.A. 39-756 and amendments thereto, to the secretary on behalf of the state only accrued, present or future rights to support from any other person such applicant may have in such person's own behalf or in behalf of any other family member for whom the applicant is applying for or receiving aid. The assignment of support rights shall automatically become effective upon the date of approval for or receipt of such aid without the requirement that any document be signed by the applicant or recipient. By applying for or receiving child care benefits or food stamps, the applicant or recipient is also deemed to have appointed the secretary, or the secretary's designee, as an attorney in fact to perform the specific act of negotiating and endorsing all drafts, checks, money orders or other negotiable instruments representing support payments received by the secretary in behalf of any person applying for, receiving or having received such assistance. This limited power of attorney shall be effective from the date the secretary approves the application for aid and shall remain in effect until the assignment of support rights has been terminated in full. An applicant or recipient who has assigned support rights to the secretary pursuant to this subsection shall cooperate in establishing and enforcing support obligations to the same extent required of applicants for or recipients of aid to families with dependent children.

Sec. 9. K.S.A. 2007 Supp. 40-19c06 is hereby amended to read as follows: 40-19c06. (a) No subscription agreement, except as provided in subsection (d), between a corporation organized under the nonprofit medical and hospital service corporation act and a subscriber, shall entitle more than one person to benefits, except that a "family subscription

agreement" may be issued, at an established subscription charge, to a husband and wife, or husband, wife, and their dependent child or children and any other person dependent upon the subscriber. Only the subscriber must be named in the subscription agreement.

(b) Every subscription agreement entered into by any such corporation with any subscriber shall be in writing and a certificate stating the terms and conditions shall be furnished to the subscriber to be kept by the subscriber. No such certificate form shall be made, issued or delivered in this state unless it contains the following provisions: (1) A statement of the nature of the benefits to be furnished and the period during which they will be furnished, and if there are any benefits to be excepted, a detailed statement of such exceptions printed as hereinafter specified; (2) a statement of the terms and conditions, if any, upon which the subscription agreement may be canceled or otherwise terminated at the option of either party; (3) a statement that the subscription agreement includes the endorsements and attached papers, if any, and contains the entire contract; (4) a statement that no statement by the subscriber in the application for a subscription agreement shall avoid the subscription agreement or be used in any legal proceeding, unless such application or an exact copy is included in or attached to such subscription agreement, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the subscription agreement or waive any of its provisions; (5) a statement that if the subscriber defaults in making any payments under the subscription agreement, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the subscription agreement but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of such acceptance; (6) a statement of the period of grace which will be allowed the subscriber for making any payment due under the subscription agreement. Such period shall not be less than 10 days; and (7) if applicable, a statement of the kind of hospital in which the subscriber may receive benefits and the types of benefits to which the subscriber may be entitled to in such kinds of hospitals. The subscriber shall be entitled to benefits in any nonparticipating hospital in Kansas which is licensed by the secretary of health and environment and in which the average length of stay of patient is similar to the average length of stay in participating hospitals. The agreements issued by any corporation currently or previously organized under this act may include provisions allowing for direct payment of benefits only to contracting health care providers.

(c) In every such subscription agreement made, issued or delivered in this state: (1) All printed portions shall be plainly printed; (2) the exceptions of the subscription agreement shall appear with the same prom-

inence as the benefits to which they apply; (3) if the subscription agreement contains any provisions purporting to make any portion of the articles of incorporation or bylaws of the corporation a part of the subscription agreement, such portion shall be set forth in full; and (4) there shall be a brief description of the subscription agreement on the first page and on its filing back.

(d) Any such corporations may issue a group or blanket subscription agreement, provided the group of persons insured conforms to the requirements of law applicable to other companies writing group or blanket sickness and accident insurance policies and provided such subscription agreement and the individual certificates issued to members of the group shall comply in substance with this section. Any such subscription agreement may provide for the adjustment of the premiums based upon the experience at the end of the first year or of any subsequent year of insurance, and such readjustment may be made retroactive in the form of a rate credit or a cash refund.

(e) (1) Any group subscription agreement issued pursuant to subsection (d) shall provide that an employee or member or such employee's or member's covered dependents whose insurance under the group subscription agreement has been terminated for any reason, including discontinuance of the group in its entirety or with respect to an insured class, and who has been continuously insured under the group subscription agreement or under any group policy or subscription agreement providing similar benefits which 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 ~~six~~ *18* months and at the end of such ~~six-month~~ *eighteen-month* period of continuation, such employee or member or such employee's or member's covered dependents shall be entitled to obtain, at the employee's, member's or dependent's option either:

(A) A converted subscription agreement providing coverage equal to 80% of that afforded under the group subscription agreement for basic hospital, surgical and medical benefits. Persons selecting this option shall also be entitled to obtain major medical expense coverage which will provide hospital, medical and surgical expense benefits to an aggregate maximum of not less than $50,000. The major medical expense coverage may be subject to a copayment by the covered person of not more than 20% of covered charges and a deductible stated on a per person, per family, per illness, per benefit period, or per year basis or a combination of such bases of not more than $500 per person subject to a maximum annual deductible of $750 per family; or

(B) a subscription agreement which imposes a deductible of not less than $1,000 per subscriber and not less than $2,000 per family and sub-

jects the covered person to a copayment of not more than 20% of covered charges with a $1,000 maximum copayment per subscriber and $2,000 maximum copayment per family per contract year and providing a lifetime maximum benefit of not less than $1,000,000.

(2) The requirements imposed by this subsection (e) shall not apply to a group subscription agreement which provides benefits for specific diseases or for accidental injuries only or any group subscription agreement 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 any employee or member or such employee's or member's covered dependents whose termination of insurance under the group subscription agreement occurred because:

(A) Such person 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;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or 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);

(C) 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; or

(D) 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. 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 subscription agreement. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection (e) in lieu of the right to continue group coverage.

(3) Written application for the converted subscription agreement shall be made and the first premium paid to the insurer not later than 31 days after termination of the group coverage and shall become effective

the day following the termination of insurance under the group subscription agreement. In addition, the converted subscription agreement shall be subject to the provisions contained in paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (10), (13), (14), (15), (16), (17), (18), (19), and (20) of subsection (j) of K.S.A. 40-2209, and amendments thereto.

Sec. 10. K.S.A. 40-2119 is hereby amended to read as follows: 40-2119. (a) There is hereby created a nonprofit legal entity to be known as the Kansas health insurance association. All insurers and insurance arrangements providing health care benefits in this state shall be members of the association. The association shall operate under a plan of operation established and approved under subsection (b) of this section and shall exercise its powers through a board of directors established under this section.

(b) (1) The board of directors of the association shall be selected by members of the association subject to the approval of the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members in this state of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after the organizational meeting, the commissioner shall appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all members are fairly represented. Members of the board may be reimbursed from the moneys of the plan for expenses incurred by them as members of the board of directors but shall not otherwise be compensated by the plan for their services.

(2) The board shall submit to the commissioner a plan of operation for the association and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this act must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if it is determined to be suitable to assure the fair, reasonable and equitable administration of the plan and provides for the sharing of association losses on an equitable proportionate basis among the members of the association. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules and regulations as are necessary or advisable to effectuate the provisions of this section. Such rules and regulations shall continue in force until modified by the commissioner or

superseded by a plan of operation submitted by the board and approved by the commissioner. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

(A) Establish procedures for the handling and accounting of assets and moneys of the plan;

(B) select an administering carrier in accordance with K.S.A. 40-2120, and amendments thereto;

(C) establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board pursuant to K.S.A. 40-2121, and amendments thereto. Assessments shall be due and payable within 30 days of receipt of the assessment notice;

(D) establish appropriate cost control measures, including but not limited to, preadmission review, case management, utilization review and exclusions and limitations with respect to treatment and services under the plan; and

(E) develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(F) Establish benefit levels, lifetime maximum benefits, and other coverage and eligibility parameters, and establish such other requirements and procedures as are necessary to assure the availability of a benefit program or programs conforming with the requirements of a qualified high risk pool as set forth in section 111 of Public Law 104-191 and amendments thereto.

(c) The association shall have the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (b). The association shall have the general powers and authority granted under the laws of this state to insurers licensed to transact the kind of health service or insurance included under K.S.A. 40-2123, and amendments thereto, and in addition thereto, the specific authority and duty to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating members;

(3) take such legal action as necessary to avoid the payment of improper claims against the association or the coverage provided by or through the plan;

(4) establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the plan. During the first two years of operation of the plan, rates shall be established in an amount that is estimated by the board to cover all claims that may be made against the plan and the expenses of operating the plan. In following years, rates for coverage shall be reasonable in terms of the benefits provided, the risk experience and expenses of providing the coverage, except that such rates shall not exceed 150% of the average premium rate charged for similar coverage in the private market. Rates and rate schedules may be adjusted for appropriate risk factors such as age, sex and geographic location in claims costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices, however particular health conditions or illnesses shall not constitute appropriate risk factors;

(5) assess members of the association in accordance with the provisions of K.S.A. 40-2121, and amendments thereto;

(6) design the policies of insurance to be offered by the plan which shall cover at least the expenses enumerated in subsection (b) of K.S.A. 40-2123, and amendments thereto, but with such limitations and optional benefit levels as the plan prescribes;

(7) issue policies of insurance in accordance with the requirements of this act; and

(8) appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

(d) The association shall administer a reinsurance program for medicare supplement policies issued to Kansas residents who are eligible for medicare by reason of disability. All medicare supplement insurers issuing or renewing medicare supplement policies in this state shall be participants in such reinsurance program. (1) On or before May 1, 2000, and each year thereafter, each issuer of a medicare supplement policy in the state shall provide to the association a calendar year accounting of the medicare supplement policies delivered or issued for delivery in the state and covering persons eligible for medicare by reason of disability who are under age 65. (2) The accounting for medicare supplement policies covering persons eligible by reason of disability and under age 65 shall include the total number of such persons covered, the total premium earned on such persons, and the total claims expense incurred with re-

spect to such persons during such year as paid through March 31, without estimates for incurred but not reported claims. (3) The association shall use such reports to develop the assessment required under subsection (d) of K.S.A. 40-2121, and amendments thereto.

(e) In addition to the requirements of this section the board is hereby authorized and directed to explore and study ways to:

(1) Expand participation in the plan by expanding persons eligible to participate in the plan; and

(2) provide for subsidization of premiums, including accessing federal grants or programs.

Sec. 11. 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~~ *$3,000,000* 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 re-

duced 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. 12. K.S.A. 2007 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 (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 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 offers such policy which 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 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 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)(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 in-

surer 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 (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 is offered through an association or trust pursuant to subsections (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 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 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 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) 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) 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 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 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 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 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 ~~six~~ *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 ~~six-month~~ *eighteen-month* period of continuation, a policy of health insurance which 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 med-

ical 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 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 terminated employee or member shall pay to the insurer the premium for the ~~six-month~~ *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 (A) (i) above for such person or benefits provided or available under the sources referred to in clauses (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 (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 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 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 (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 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 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 (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 (A)(i) of this paragraph or 24 months when the maximum benefit is determined by clause (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 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 is delivered outside this state must be on a form which 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 ~~six-month~~ *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 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. 13. K.S.A. 40-2209d is hereby amended to read as follows: 40-2209d. As used in this 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 the Kansas Statutes Annotated, 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 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.* "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 as in subsection (d) of 26 U.S.C. Section 223.

(n) "High deductible health plan" shall mean 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 and any regulations promulgated thereunder.

~~(m)~~ *(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.

~~(n)~~ *(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.

~~(o)~~ *(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.

~~(p)~~ *(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.

~~(q)~~ *(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.

~~(r)~~ *(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.

~~(s)~~ *(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.

~~(t)~~ *(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.

~~(u)~~ *(w)* "Small employer" means any person, firm, corporation, 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, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, provisions of this act which apply to a small employer which 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.

~~(v)~~ *(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.

Sec. 14. K.S.A. 40-2209m is hereby amended to read as follows: 40-2209m. (a) Each small employer carrier shall actively market *all* health

benefit ~~plan~~ *plans* ~~coverage~~ *sold by the carrier in the small group market* to eligible small employers in the state.

(b) (1) Except as provided in paragraph (2), no small employer carrier, agent or broker shall, directly or indirectly, engage in the following activities:

(A) Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer;

(B) encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) The provisions of paragraph (1) shall not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(c) (1) Except as provided in paragraph (2), no small employer carrier shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or broker that provides for or results in the compensation paid to such person for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(2) Paragraph (1) shall not apply with respect to a compensation arrangement that provides compensation to an agent or broker on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.

(d) No small employer carrier shall terminate, fail to renew or limit its contract or agreement of representation with an agent or broker for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent or broker with the small employer carrier.

(e) No small employer carrier, agent or broker shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(f) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(g) The commissioner may adopt rules and regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(h) If a small employer carrier enters into a contract, agreement or

other arrangement with a third-party administrator to provide administrative, marketing or other services related to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section as if it were a small employer carrier.

(i) Except as provided in ~~paragraph (l)~~ *subsection (j)*, for the purposes of this act, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this act shall apply as if all health benefit plans issued to small employers in this state by such affiliated carriers were issued by one carrier.

(j) An affiliated carrier that is a health maintenance organization having a certificate of authority under K.S.A. 40-3201 et seq. and amendments thereto, may be considered to be a separate carrier for the purpose of this act.

Sec. 15. K.S.A. 2007 Supp. 40-2240 is hereby amended to read as follows: 40-2240. (a) Any small employer as defined in subsection (4) of K.S.A. 40-2209d, and amendments thereto, may establish a small employer health benefit plan for the purpose of providing a health benefit plan as described in subsection (u) of K.S.A. 40-2209d, and amendments thereto, covering such employers' eligible employees and such employees' family members. If an association or trust is used for such purposes, the association or trust may not condition eligibility or membership on the health status of members or employees.

(b) The commissioner shall provide assistance to employers desiring to organize and maintain any such benefit plan and may aid in the acquisition of the health care insurance by the small employer health benefit plan.

(c) Any health benefit plan may:

(1) Be offered through a cafeteria plan authorized by 26 U.S.C. Section 125.

(2) Offer to all eligible individuals the option of receiving health care coverage through a high deductible plan and the establishment of a health savings account.

(d) For the purposes of this section, the term:

(1) "Health savings account" shall have the meaning ascribed to it in subsection (d) of 26 U.S.C. Section 223.

(2) "High deductible health plan" shall mean 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 and any regulations promulgated thereunder.

Sec. 16. K.S.A. 2007 Supp. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of group and individual certificates of coverage and contracts issued by the organization to enrollees or other mar-

keting documents purporting to describe the organization's health care services shall contain as a minimum:

(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) The locations of all facilities, the hours of operation and the services which are provided in each facility in the case of individual practice associations or medical staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers;

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services;

(7) in the case of a health maintenance organization, a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization or under any group policy providing similar benefits which it replaces for at least three months immediately prior to termination shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of ~~six~~ *18* months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such em-

ployee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured 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. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (17) and (19) of subsection (j) of K.S.A. 40-2209, and amendments thereto;

(8) (A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract, whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of termination;

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A); and

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services.

(b) No health maintenance organization or medicare provider organization authorized under this act shall contract with any provider under

provisions which require enrollees to guarantee payment, other than co-payments and deductibles, to such provider in the event of nonpayment by the health maintenance organization or medicare provider organization for any services which have been performed under contracts between such enrollees and the health maintenance organization or medicare provider organization. Further, any contract between a health maintenance organization or medicare provider organization and a provider shall provide that if the health maintenance organization or medicare provider organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization or medicare provider organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. If there is no written contract between the health maintenance organization or medicare provider organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization or medicare provider organization. Any action by a provider to collect or attempt to collect from a subscriber or enrollee any sum owed by the health maintenance organization to a provider shall be deemed to be an unconscionable act within the meaning of K.S.A. 50-627 and amendments thereto.

(c) No group or individual certificate of coverage or contract form or amendment to an approved certificate of coverage or contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's or medicare provider organization's method for resolving enrollee grievances.

(e) The provisions of subsections (A), (B), (C), (D) and (E) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

(f) In lieu of any of the requirements of subsection (a), the commissioner may accept certificates of coverage issued by a medicare provider organization in conformity with requirements imposed by any appropriate federal regulatory agency.

Sec. 17. K.S.A. 2007 Supp. 65-7402 is hereby amended to read as follows: 65-7402. As used in the primary care safety net clinic capital loan guarantee act:

(a) "Act" means the primary care safety net clinic capital loan guar-

antee act;

(b) "community health center" means an entity that receives funding under section 330 of the federal health center consolidation act of 1996 and meets all of the requirements of 42 USC section 254b, relating to serving a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through staff and supporting resources of the center or through contracts or cooperative arrangements, all required primary health services as defined by 42 USC section 254b;

(c) "federally-qualified health center look-alike" means an entity which has been determined by the federal health resources and services administration to meet the definition of a federally qualified health center as defined by section 1905(l)(2)(B) of the federal social security act, but which does not receive funding under section 330 of the federal health center consolidation act of 1996;

(d) "financial institution" means any bank, trust company, savings bank, credit union or savings and loan association or any other financial institution regulated by the state of Kansas, any agency of the United States or other state with an office in Kansas which is approved by the secretary for the purposes of this act;

(e) *"hospital clinic" means health services provided as a part of the emergency services of a hospital licensed under K.S.A. 65-425 et seq., and amendments thereto, but on a non-acute care basis;*

(f) "indigent health care clinic" means an outpatient medical care clinic operated on a not-for-profit basis which has a contractual agreement in effect with the secretary of health and environment under K.S.A. 75-6120 and amendments thereto to provide health care services to medically indigent persons;

~~(f)~~ *(g)* "loan transaction" means a transaction with a financial institution or the Kansas development finance authority to provide capital financing for the renovation, construction, acquisition, modernization, leasehold improvement or equipping of a primary care safety net clinic;

~~(g)~~ *(h)* "medically indigent person" means a person who lacks resources to pay for medically necessary health care services and who meets the eligibility criteria for qualification as a medically indigent person established by the secretary of health and environment under K.S.A. 75-6120 and amendments thereto;

~~(h)~~ *(i)* "primary care safety net clinic" means a community health center, a federally-qualified health center look-alike ~~or~~, an indigent health care clinic *or a hospital clinic*; and

~~(i)~~ *(j)* "secretary" means the secretary of health and environment.

Sec. 18. K.S.A. 2007 Supp. 65-7403 is hereby amended to read as

follows: 65-7403. (a) *Except as otherwise provided in this section,* the secretary is hereby authorized to enter into agreements with primary care safety net clinics, financial institutions, the Kansas development finance authority and other public or private entities, including agencies of the United States government to provide capital loan guarantees against risk of default for eligible primary care safety net clinics in Kansas in accordance with this act. Except as provided in K.S.A. 2007 Supp. 65-7406, and amendments thereto, for payment for a loan guarantee for which the primary care safety net clinic loan guarantee fund is liable, no claim against the state under this act shall be paid by the state, the secretary of health and environment or any other state agency other than pursuant to an appropriation act of the legislature after such claim has been filed with and considered by the joint committee on special claims against the state. *The secretary may enter into agreements with hospital clinics for such clinics to act as primary care safety net clinics.*

(b) To be eligible for a capital loan guarantee under this act, a primary care safety net clinic shall offer a sliding fee discount for health care and other services provided that is based upon household income and shall serve all persons regardless of ability to pay. The policies to determine patient eligibility based upon income or insurance status may be determined by each primary care safety net clinic, but shall be posted in the primary care safety net clinic and available to potential patients. The patient eligibility policies of a primary care safety net clinic shall reflect the mission of the primary care safety net clinic to provide affordable, accessible primary care to underserved populations in Kansas to be eligible for a capital loan guarantee under this act.

(c) The secretary shall administer the provisions of this act and shall adopt rules and regulations which the secretary deems necessary for the implementation or administration of this act. The loan guarantee agreement with the secretary shall include reporting requirements and financial standards that are appropriate for the type of loan for the borrower. The secretary may enter into contracts that the secretary deems necessary for the implementation or administration of this act. The secretary may impose fees and charges as may be necessary to recover costs incurred for the administration of this act.

Sec. 19. K.S.A. 2007 Supp. 75-6501 is hereby amended to read as follows: 75-6501. (a) Within the limits of appropriations made or available therefor and subject to the provisions of appropriation acts relating thereto, the Kansas state employees health care commission shall develop and provide for the implementation and administration of a state health care benefits program.

(b) The state health care benefits program may provide benefits for persons qualified to participate in the program for hospitalization, medical

services, surgical services, nonmedical remedial care and treatment rendered in accordance with a religious method of healing and other health services. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

(c) The Kansas state employees health care commission shall designate by rules and regulations those persons who are qualified to participate in the state health care benefits program, including active and retired public officers and employees and their dependents as defined by rules and regulations of the commission. Such rules and regulations shall not apply to students attending a state educational institution as defined in K.S.A. 76-711, and amendments thereto, who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto. In designating persons qualified to participate in the state health care benefits program, the commission may establish such conditions, restrictions, limitations and exclusions as the commission deems reasonable. Such conditions, restrictions, limitations and exclusions shall include the conditions contained in subsection (d) of K.S.A. 75-6506, and amendments thereto. Each person who was formerly elected or appointed and qualified to an elective state office and who was covered immediately preceding the date such person ceased to hold such office by the provisions of group health insurance or a health maintenance organization plan under the law in effect prior to August 1, 1984, or the state health care benefits program in effect after that date, shall continue to be qualified to participate in the state health care benefits program and shall pay the cost of participation in the program as established and in accordance with the procedures prescribed by the commission if such person chooses to participate therein.

(d) As an alternative to any other coverage provided under the state health care benefit program, the commission shall provide and offer to any qualified person a health care benefits program which provides coverage which is the actuarial equivalent of the minimum federal benefits requirement for the medicaid program.

(e) The state's employer contribution to any health savings account plan offered to state employees shall be equal to the state's employer contribution to any fully insured plans offered to state employees.

~~(d)~~ *(f)* The commission shall have no authority to assess charges for employer contributions under the student health care benefits compo-

nent of the state health care benefits program for persons who are covered by insurance contracts entered into by the board of regents pursuant to K.S.A. 75-4101, and amendments thereto.

~~(e)~~ *(g)* Nothing in this act shall be construed to permit the Kansas state employees health care commission to discontinue the student health care benefits component of the state health care benefits program until the state board of regents has contracts in effect that provide student coverage pursuant to the authority granted therefor in K.S.A. 75-4101, and amendments thereto.

Sec. 20. K.S.A. 2007 Supp. 75-7427 is hereby amended to read as follows: 75-7427. (a) As used in this section:

(1) "Attorney general" means the attorney general, employees of the attorney general or authorized representatives of the attorney general.

(2) "Benefit" means the receipt of money, goods, items, facilities, accommodations or anything of pecuniary value.

(3) "Claim" means an electronic, electronic impulse, facsimile, magnetic, oral, telephonic or written communication that is utilized to identify any goods, service, item, facility or accommodation as reimbursable to the state medicaid program, or its fiscal agents, the state mediKan program or the state children's health insurance program or which states income or expense.

(4) "Client" means past or present beneficiaries or recipients of the state medicaid program, the state mediKan program or the state children's health insurance program.

(5) "Contractor" means any contractor, supplier, vendor or other person who, through a contract or other arrangement, has received, is to receive or is receiving public funds or in-kind contributions from the contracting agency as part of the state medicaid program, the state mediKan program or the state children's health insurance program, and shall include any sub-contractor.

(6) "Contractor files" means those records of contractors which relate to the state medicaid program, the state mediKan program or the state children's health insurance program.

(7) "Fiscal agent" means any corporation, firm, individual, organization, partnership, professional association or other legal entity which, through a contractual relationship with the state of Kansas receives, processes and pays claims under the state medicaid program, the state mediKan program or the state children's health insurance program.

(8) "Health care provider" means a health care provider as defined under K.S.A. 65-4921, and amendments thereto, who has applied to participate in, who currently participates in, or who has previously participated in the state medicaid program, the state mediKan program or the state children's health insurance program.

(9) "Kansas health policy authority" or "authority" means the Kansas health policy authority established under K.S.A. 2007 Supp. 75-7401, and amendments thereto, or its successor agency.

(10) "Managed care program" means a program which provides coordination, direction and provision of health services to an identified group of individuals by providers, agencies or organizations.

(11) "Medicaid program" means the Kansas program of medical assistance for which federal or state moneys, or any combination thereof, are expended, or any successor federal or state, or both, health insurance program or waiver granted thereunder.

(12) "Person" means any agency, association, corporation, firm, limited liability company, limited liability partnership, natural person, organization, partnership or other legal entity, the agents, employees, independent contractors, and subcontractors, thereof, and the legal successors thereto.

(13) "Provider" means a person who has applied to participate in, who currently participates in, who has previously participated in, who attempts or has attempted to participate in the state medicaid program, the state mediKan program or the state children's health insurance program, by providing or claiming to have provided goods, services, items, facilities or accommodations.

(14) "Recipient" means an individual, either real or fictitious, in whose behalf any person claimed or received any payment or payments from the state medicaid program, or its fiscal agent, the state mediKan program or the state children's health insurance program, whether or not any such individual was eligible for benefits under the state medicaid program, the state mediKan program or the state children's health insurance program.

(15) "Records" means all written documents and electronic or magnetic data, including, but not limited to, medical records, X-rays, professional, financial or business records relating to the treatment or care of any recipient; goods, services, items, facilities or accommodations provided to any such recipient; rates paid for such goods, services, items, facilities or accommodations; and goods, services, items, facilities or accommodations provided to nonmedicaid recipients to verify rates or amounts of goods, services, items, facilities or accommodations provided to medicaid recipients, as well as any records that the state medicaid program, or its fiscal agents, the state mediKan program or the state children's health insurance program require providers to maintain. "Records" shall not include any report or record in any format which is made pursuant to K.S.A. 65-4922, 65-4923 or 65-4924, and amendments thereto, and which is privileged pursuant to K.S.A. 65-4915 or 65-4925, and amendments thereto.

(16) "State children's health insurance program" means the state children's health insurance program as provided in K.S.A. 38-2001 et seq., and amendments thereto.

(b) (1) There is hereby established within the Kansas health policy authority the office of inspector general. All budgeting, purchasing and related management functions of the office of inspector general shall be administered under the direction and supervision of the executive director of the Kansas health policy authority. The purpose of the office of inspector general is to establish a full-time program of audit, investigation and performance review to provide increased accountability, integrity and oversight of the state medicaid program, the state mediKan program and the state children's health insurance program within the jurisdiction of the Kansas health policy authority and to assist in improving agency and program operations and in deterring and identifying fraud, waste, abuse and illegal acts. The office of inspector general shall be independent and free from political influence and in performing the duties of the office under this section shall conduct investigations, audits, evaluations, inspections and other reviews in accordance with professional standards that relate to the fields of investigation and auditing in government.

(2) (A) The inspector general shall be appointed by the Kansas health policy authority with the advice and consent of the senate and subject to confirmation by the senate as provided in K.S.A. 75-4315b, and amendments thereto. Except as provided in K.S.A. 46-2601, and amendments thereto, no person appointed to the position of inspector general shall exercise any power, duty or function of the inspector general until confirmed by the senate. The inspector general shall be selected without regard to political affiliation and on the basis of integrity and capacity for effectively carrying out the duties of the office of inspector general. The inspector general shall possess demonstrated knowledge, skills, abilities and experience in conducting audits or investigations and shall be familiar with the programs subject to oversight by the office of inspector general.

(B) No former or current executive or manager of any program or agency subject to oversight by the office of inspector general may be appointed inspector general within two years of that individual's period of service with such program or agency. The inspector general shall hold at time of appointment, or shall obtain within one year after appointment, certification as a certified inspector general from a national organization that provides training to inspectors general.

(C) The term of the person first appointed to the position of inspector general shall expire on January 15, 2009. Thereafter, a person appointed to the position of inspector general shall serve for a term which shall expire on January 15 of each year in which the whole senate is sworn in for a new term.

(D) The inspector general shall be in the classified service and shall receive such compensation as is determined by law, except that such compensation may be increased but not diminished during the term of office of the inspector general. The inspector general may be removed from office prior to the expiration of the inspector general's term of office in accordance with the Kansas civil service act. The inspector general shall exercise independent judgment in carrying out the duties of the office of inspector general under subsection (b). Appropriations for the office of inspector general shall be made to the Kansas health policy authority by separate line item appropriations for the office of inspector general. The inspector general shall report to ~~the executive director of~~ the Kansas health policy authority.

(E) The inspector general shall have general managerial control over the office of the inspector general and shall establish the organization structure of the office as the inspector general deems appropriate to carry out the responsibilities and functions of the office.

(3) Within the limits of appropriations therefor, the inspector general may hire such employees in the unclassified service as are necessary to administer the office of the inspector general. Such employees shall serve at the pleasure of the inspector general. Subject to appropriations, the inspector general may obtain the services of certified public accountants, qualified management consultants, professional auditors, or other professionals necessary to independently perform the functions of the office.

(c) (1) In accordance with the provisions of this section, the duties of the office of inspector general shall be to oversee, audit, investigate and make performance reviews of the state medicaid program, the state mediKan program and the state children's health insurance program, which programs are within the jurisdiction of the Kansas health policy authority.

(2) In order to carry out the duties of the office, the inspector general shall conduct independent and ongoing evaluation of the Kansas health policy authority and of such programs administered by the Kansas health policy authority, which oversight includes, but is not limited to, the following:

(A) Investigation of fraud, waste, abuse and illegal acts by the Kansas health policy authority and its agents, employees, vendors, contractors, consumers, clients and health care providers or other providers.

(B) Audits of the Kansas health policy authority, its employees, contractors, vendors and health care providers related to ensuring that appropriate payments are made for services rendered and to the recovery of overpayments.

(C) Investigations of fraud, waste, abuse or illegal acts committed by clients of the Kansas health policy authority or by consumers of services

administered by the Kansas health policy authority.

(D) Monitoring adherence to the terms of the contract between the Kansas health policy authority and an organization with which the authority has entered into a contract to make claims payments.

(3) Upon finding credible evidence of fraud, waste, abuse or illegal acts, the inspector general shall report its findings to the Kansas health policy authority and refer the findings to the attorney general.

(d) The inspector general shall have access to all pertinent information, confidential or otherwise, and to all personnel and facilities of the Kansas health policy authority, their employees, vendors, contractors and health care providers and any federal, state or local governmental agency that are necessary to perform the duties of the office as directly related to such programs administered by the authority. Access to contractor or health care provider files shall be limited to those files necessary to verify the accuracy of the contractor's or health care provider's invoices or their compliance with the contract provisions or program requirements. No health care provider shall be compelled under the provisions of this section to provide individual medical records of patients who are not clients of the state medicaid program, the state mediKan program or the state children's health insurance program. State and local governmental agencies are authorized and directed to provide to the inspector general requested information, assistance or cooperation.

(e) Except as otherwise provided in this section, the inspector general and all employees and former employees of the office of inspector general shall be subject to the same duty of confidentiality imposed by law on any such person or agency with regard to any such information, and shall be subject to any civil or criminal penalties imposed by law for violations of such duty of confidentiality. The duty of confidentiality imposed on the inspector general and all employees and former employees of the office of inspector general shall be subject to the provisions of subsection (f), and the inspector general may furnish all such information to the attorney general, Kansas bureau of investigation or office of the United States attorney in Kansas pursuant to subsection (f). Upon receipt thereof, the attorney general, Kansas bureau of investigation or office of the United States attorney in Kansas and all assistants and all other employees and former employees of such offices shall be subject to the same duty of confidentiality with the exceptions that any such information may be disclosed in criminal or other proceedings which may be instituted and prosecuted by the attorney general or the United States attorney in Kansas, and any such information furnished to the attorney general, the Kansas bureau of investigation or the United States attorney in Kansas under subsection (f) may be entered into evidence in any such proceedings.

(f) All investigations conducted by the inspector general shall be con-

ducted in a manner that ensures the preservation of evidence for use in criminal prosecutions or agency administrative actions. If the inspector general determines that a possible criminal act relating to fraud in the provision or administration of such programs administered by the Kansas health policy authority has been committed, the inspector general shall immediately notify the office of the Kansas attorney general. If the inspector general determines that a possible criminal act has been committed within the jurisdiction of the office, the inspector general may request the special expertise of the Kansas bureau of investigation. The inspector general may present for prosecution the findings of any criminal investigation to the office of the attorney general or the office of the United States attorney in Kansas.

(g) To carry out the duties as described in this section, the inspector general and the inspector general's designees shall have the power to compel by subpoena the attendance and testimony of witnesses and the production of books, electronic records and papers as directly related to such programs administered by the Kansas health policy authority. Access to contractor files shall be limited to those files necessary to verify the accuracy of the contractor's invoices or its compliance with the contract provisions. No health care provider shall be compelled to provide individual medical records of patients who are not clients of the authority.

(h) The inspector general shall report all convictions, terminations and suspensions taken against vendors, contractors and health care providers to the Kansas health policy authority and to any agency responsible for licensing or regulating those persons or entities. If the inspector general determines reasonable suspicion exists that an act relating to the violation of an agency licensure or regulatory standard has been committed by a vendor, contractor or health care provider who is licensed or regulated by an agency, the inspector general shall immediately notify such agency of the possible violation.

(i) The inspector general shall make annual reports, findings and recommendations regarding the office's investigations into reports of fraud, waste, abuse and illegal acts relating to any such programs administered by the Kansas health policy authority to the executive director of the Kansas health policy authority, the legislative post auditor, the committee on ways and means of the senate, the committee on appropriations of the house of representatives, the joint committee on health policy oversight and the governor. These reports shall include, but not be limited to, the following information:

(1) Aggregate provider billing and payment information;

(2) the number of audits of such programs administered by the Kansas health policy authority and the dollar savings, if any, resulting from those audits;

(3) health care provider sanctions, in the aggregate, including terminations and suspensions; and

(4) a detailed summary of the investigations undertaken in the previous fiscal year, which summaries shall comply with all laws and rules and regulations regarding maintaining confidentiality in such programs administered by the Kansas health policy authority.

(j) Based upon the inspector general's findings under subsection (c), the inspector general may make such recommendations to the Kansas health policy authority or the legislature for changes in law, rules and regulations, policy or procedures as the inspector general deems appropriate to carry out the provisions of law or to improve the efficiency of such programs administered by the Kansas health policy authority. The inspector general shall not be required to obtain permission or approval from any other official or authority prior to making any such recommendation.

(k) (1) The inspector general shall make provision to solicit and receive reports of fraud, waste, abuse and illegal acts in such programs administered by the Kansas health policy authority from any person or persons who shall possess such information. The inspector general shall not disclose or make public the identity of any person or persons who provide such reports pursuant to this subsection unless such person or persons consent in writing to the disclosure of such person's identity. Disclosure of the identity of any person who makes a report pursuant to this subsection shall not be ordered as part of any administrative or judicial proceeding. Any information received by the inspector general from any person concerning fraud, waste, abuse or illegal acts in such programs administered by the Kansas health policy authority shall be confidential and shall not be disclosed or made public, upon subpoena or otherwise, except such information may be disclosed if (A) release of the information would not result in the identification of the person who provided the information, (B) the person or persons who provided the information to be disclosed consent in writing prior to its disclosure, (C) the disclosure is necessary to protect the public health, or (D) the information to be disclosed is required in an administrative proceeding or court proceeding and appropriate provision has been made to allow disclosure of the information without disclosing to the public the identity of the person or persons who reported such information to the inspector general.

(2) No person shall:

(A) Prohibit any agent, employee, contractor or subcontractor from reporting any information under subsection (k)(1); or

(B) require any such agent, employee, contractor or subcontractor to give notice to the person prior to making any such report.

(3) Subsection (k)(2) shall not be construed as:

(A) Prohibiting an employer from requiring that an employee inform the employer as to legislative or auditing agency requests for information or the substance of testimony made, or to be made, by the employee to legislators or the auditing agency, as the case may be, on behalf of the employer;

(B) permitting an employee to leave the employee's assigned work areas during normal work hours without following applicable rules and regulations and policies pertaining to leaves, unless the employee is requested by a legislator or legislative committee to appear before a legislative committee or by an auditing agency to appear at a meeting with officials of the auditing agency;

(C) authorizing an employee to represent the employee's personal opinions as the opinions of the employer; or

(D) prohibiting disciplinary action of an employee who discloses information which (A) the employee knows to be false or which the employee discloses with reckless disregard for its truth or falsity, (B) the employee knows to be exempt from required disclosure under the open records act, or (C) is confidential or privileged under statute or court rule.

(4) Any agent, employee, contractor or subcontractor who alleges that disciplinary action has been taken against such agent, employee, contractor or subcontractor in violation of this section may bring an action for any damages caused by such violation in district court within 90 days after the occurrence of the alleged violation.

(5) Any disciplinary action taken against an employee of a state agency or firm as such terms are defined under subsection (b) of K.S.A. 75-2973, and amendments thereto, for making a report under subsection (k)(1) shall be governed by the provisions of K.S.A. 75-2973, and amendments thereto.

(l) The scope, timing and completion of any audit or investigation conducted by the inspector general shall be within the discretion of the inspector general. Any audit conducted by the inspector general's office shall adhere and comply with all provisions of generally accepted governmental auditing standards promulgated by the United States government accountability office.

(m) Nothing in this section shall limit investigations by any state department or agency that may otherwise be required by law or that may be necessary in carrying out the duties and functions of such agency.

(n) No contractor who has been convicted of fraud, waste, abuse or illegal acts or whose actions have caused the state of Kansas to pay fines to or reimburse the federal government more than $1,000,000 in the medicaid program shall be eligible for any state medicaid contracts subsequent to such conviction unless the Kansas health policy authority finds that the contractor is the sole source for such contracts, is the least expensive

source for the contract or has reimbursed the state of Kansas for all losses caused by the contractor, in which case the authority after a specific finding to this effect may waive the prohibition of this subsection.

~~(n)~~ *(o)* The Kansas health policy authority, in accordance with K.S.A. 75-4319, and amendments thereto, may recess for a closed, executive meeting under the open meetings act, K.S.A. 75-4317 through 75-4320a, and amendments thereto, to discuss with the inspector general any information, records or other matters that are involved in any investigation or audit under this section. All information and records of the inspector general that are obtained or received under any investigation or audit under this section shall be confidential, except as required or authorized pursuant to this section.

Sec. 21. K.S.A. 2007 Supp. 75-7423 is hereby amended to read as follows: 75-7423. *During the interim legislative period between the end of the 2008 legislative session and the commencement of the 2009 legislative session,* the Kansas health policy authority in consultation with the joint committee on health policy oversight shall consider as part of the health reform in Kansas various medicaid reform options including, but not limited to: The experience of other states, long-term care, waste, fraud and abuse, health opportunity accounts, tax credits, vouchers and premium assistance, and wellness as provided through the federal deficit reduction act of 2005. Such medicaid reforms should result in improved health outcomes for medicaid recipients, long-term cost controls and encourage primary and preventive care which will result in cost savings for the state. *The Kansas health policy authority shall report its findings and recommendations to the governor and to the legislature on or before January 12, 2009.*

Sec. 22. K.S.A. 2007 Supp. 79-32,117 is hereby amended to read as follows: 79-32,117. (a) The Kansas adjusted gross income of an individual means such individual's federal adjusted gross income for the taxable year, with the modifications specified in this section.

(b) There shall be added to federal adjusted gross income:

(i) Interest income less any related expenses directly incurred in the purchase of state or political subdivision obligations, to the extent that the same is not included in federal adjusted gross income, on obligations of any state or political subdivision thereof, but to the extent that interest income on obligations of this state or a political subdivision thereof issued prior to January 1, 1988, is specifically exempt from income tax under the laws of this state authorizing the issuance of such obligations, it shall be excluded from computation of Kansas adjusted gross income whether or not included in federal adjusted gross income. Interest income on obligations of this state or a political subdivision thereof issued after December 31, 1987, shall be excluded from computation of Kansas adjusted

gross income whether or not included in federal adjusted gross income.

(ii) Taxes on or measured by income or fees or payments in lieu of income taxes imposed by this state or any other taxing jurisdiction to the extent deductible in determining federal adjusted gross income and not credited against federal income tax. This paragraph shall not apply to taxes imposed under the provisions of K.S.A. 79-1107 or 79-1108, and amendments thereto, for privilege tax year 1995, and all such years thereafter.

(iii) The federal net operating loss deduction.

(iv) Federal income tax refunds received by the taxpayer if the deduction of the taxes being refunded resulted in a tax benefit for Kansas income tax purposes during a prior taxable year. Such refunds shall be included in income in the year actually received regardless of the method of accounting used by the taxpayer. For purposes hereof, a tax benefit shall be deemed to have resulted if the amount of the tax had been deducted in determining income subject to a Kansas income tax for a prior year regardless of the rate of taxation applied in such prior year to the Kansas taxable income, but only that portion of the refund shall be included as bears the same proportion to the total refund received as the federal taxes deducted in the year to which such refund is attributable bears to the total federal income taxes paid for such year. For purposes of the foregoing sentence, federal taxes shall be considered to have been deducted only to the extent such deduction does not reduce Kansas taxable income below zero.

(v) The amount of any depreciation deduction or business expense deduction claimed on the taxpayer's federal income tax return for any capital expenditure in making any building or facility accessible to the handicapped, for which expenditure the taxpayer claimed the credit allowed by K.S.A. 79-32,177, and amendments thereto.

(vi) Any amount of designated employee contributions picked up by an employer pursuant to K.S.A. 12-5005, 20-2603, 74-4919 and 74-4965, and amendments to such sections.

(vii) The amount of any charitable contribution made to the extent the same is claimed as the basis for the credit allowed pursuant to K.S.A. 79-32,196, and amendments thereto.

(viii) The amount of any costs incurred for improvements to a swine facility, claimed for deduction in determining federal adjusted gross income, to the extent the same is claimed as the basis for any credit allowed pursuant to K.S.A. 2007 Supp. 79-32,204 and amendments thereto.

(ix) The amount of any ad valorem taxes and assessments paid and the amount of any costs incurred for habitat management or construction and maintenance of improvements on real property, claimed for deduction in determining federal adjusted gross income, to the extent the same is claimed as the basis for any credit allowed pursuant to K.S.A. 79-32,203

and amendments thereto.

(x) Amounts received as nonqualified withdrawals, as defined by K.S.A. 2007 Supp. 75-643, and amendments thereto, if, at the time of contribution to a family postsecondary education savings account, such amounts were subtracted from the federal adjusted gross income pursuant to paragraph (xv) of subsection (c) of K.S.A. 79-32,117, and amendments thereto, or if such amounts are not already included in the federal adjusted gross income.

(xi) The amount of any contribution made to the same extent the same is claimed as the basis for the credit allowed pursuant to K.S.A. 2007 Supp. 74-50,154, and amendments thereto.

(xii) For taxable years commencing after December 31, 2004, amounts received as withdrawals not in accordance with the provisions of K.S.A. 2007 Supp. 74-50,204, and amendments thereto, if, at the time of contribution to an individual development account, such amounts were subtracted from the federal adjusted gross income pursuant to paragraph (xiii) of subsection (c), or if such amounts are not already included in the federal adjusted gross income.

(xiii) The amount of any expenditures claimed for deduction in determining federal adjusted gross income, to the extent the same is claimed as the basis for any credit allowed pursuant to K.S.A. 2007 Supp. 79-32,217 through 79-32,220 or 79-32,222, and amendments thereto.

(xiv) The amount of any amortization deduction claimed in determining federal adjusted gross income to the extent the same is claimed for deduction pursuant to K.S.A. 2007 Supp. 79-32,221, and amendments thereto.

(xv) The amount of any expenditures claimed for deduction in determining federal adjusted gross income, to the extent the same is claimed as the basis for any credit allowed pursuant to K.S.A. 2007 Supp. 79-32,223 through 79-32,226, 79-32,228 through 79-32,231, 79-32,233 through 79-32,236, 79-32,238 through 79-32,241, 79-32,245 through 79-32,248 or 79-32,251 through 79-32,254, and amendments thereto.

(xvi) The amount of any amortization deduction claimed in determining federal adjusted gross income to the extent the same is claimed for deduction pursuant to K.S.A. 2007 Supp. 79-32,227, 79-32,232, 79-32,237, 79-32,249, 79-32,250 or 79-32,255, and amendments thereto.

(xvii) The amount of any amortization deduction claimed in determining federal adjusted gross income to the extent the same is claimed for deduction pursuant to K.S.A. 2007 Supp. 79-32,256, and amendments thereto.

(c) There shall be subtracted from federal adjusted gross income:

(i) Interest or dividend income on obligations or securities of any authority, commission or instrumentality of the United States and its pos-

sessions less any related expenses directly incurred in the purchase of such obligations or securities, to the extent included in federal adjusted gross income but exempt from state income taxes under the laws of the United States.

(ii) Any amounts received which are included in federal adjusted gross income but which are specifically exempt from Kansas income taxation under the laws of the state of Kansas.

(iii) The portion of any gain or loss from the sale or other disposition of property having a higher adjusted basis for Kansas income tax purposes than for federal income tax purposes on the date such property was sold or disposed of in a transaction in which gain or loss was recognized for purposes of federal income tax that does not exceed such difference in basis, but if a gain is considered a long-term capital gain for federal income tax purposes, the modification shall be limited to that portion of such gain which is included in federal adjusted gross income.

(iv) The amount necessary to prevent the taxation under this act of any annuity or other amount of income or gain which was properly included in income or gain and was taxed under the laws of this state for a taxable year prior to the effective date of this act, as amended, to the taxpayer, or to a decedent by reason of whose death the taxpayer acquired the right to receive the income or gain, or to a trust or estate from which the taxpayer received the income or gain.

(v) The amount of any refund or credit for overpayment of taxes on or measured by income or fees or payments in lieu of income taxes imposed by this state, or any taxing jurisdiction, to the extent included in gross income for federal income tax purposes.

(vi) Accumulation distributions received by a taxpayer as a beneficiary of a trust to the extent that the same are included in federal adjusted gross income.

(vii) Amounts received as annuities under the federal civil service retirement system from the civil service retirement and disability fund and other amounts received as retirement benefits in whatever form which were earned for being employed by the federal government or for service in the armed forces of the United States.

(viii) Amounts received by retired railroad employees as a supplemental annuity under the provisions of 45 U.S.C. 228b (a) and 228c (a)(1) et seq.

(ix) Amounts received by retired employees of a city and by retired employees of any board of such city as retirement allowances pursuant to K.S.A. 13-14,106, and amendments thereto, or pursuant to any charter ordinance exempting a city from the provisions of K.S.A. 13-14,106, and amendments thereto.

(x) For taxable years beginning after December 31, 1976, the amount

of the federal tentative jobs tax credit disallowance under the provisions of 26 U.S.C. 280 C. For taxable years ending after December 31, 1978, the amount of the targeted jobs tax credit and work incentive credit disallowances under 26 U.S.C. 280 C.

(xi) For taxable years beginning after December 31, 1986, dividend income on stock issued by Kansas Venture Capital, Inc.

(xii) For taxable years beginning after December 31, 1989, amounts received by retired employees of a board of public utilities as pension and retirement benefits pursuant to K.S.A. 13-1246, 13-1246a and 13-1249 and amendments thereto.

(xiii) For taxable years beginning after December 31, 2004, amounts contributed to and the amount of income earned on contributions deposited to an individual development account under K.S.A. 2007 Supp. 74-50,201, et seq., and amendments thereto.

(xiv) For all taxable years commencing after December 31, 1996, that portion of any income of a bank organized under the laws of this state or any other state, a national banking association organized under the laws of the United States, an association organized under the savings and loan code of this state or any other state, or a federal savings association organized under the laws of the United States, for which an election as an S corporation under subchapter S of the federal internal revenue code is in effect, which accrues to the taxpayer who is a stockholder of such corporation and which is not distributed to the stockholders as dividends of the corporation.

(xv) For all taxable years beginning after December 31, 2006, amounts not exceeding $3,000, or $6,000 for a married couple filing a joint return, for each designated beneficiary which are contributed to a family postsecondary education savings account established under the Kansas postsecondary education savings program or a qualified tuition program established and maintained by another state or agency or instrumentality thereof pursuant to section 529 of the internal revenue code of 1986, as amended, for the purpose of paying the qualified higher education expenses of a designated beneficiary at an institution of postsecondary education. The terms and phrases used in this paragraph shall have the meaning respectively ascribed thereto by the provisions of K.S.A. 2007 Supp. 75-643, and amendments thereto, and the provisions of such section are hereby incorporated by reference for all purposes thereof.

(xvi) For the tax year beginning after December 31, 2004, an amount not exceeding $500; for the tax year beginning after December 31, 2005, an amount not exceeding $600; for the tax year beginning after December 31, 2006, an amount not exceeding $700; for the tax year beginning after December 31, 2007, an amount not exceeding $800; for the tax year beginning December 31, 2008, an amount not exceeding $900; and for

all taxable years commencing after December 31, 2009, an amount not exceeding $1,000 of the premium costs for qualified long-term care insurance contracts, as defined by subsection (b) of section 7702B of public law 104-191.

(xvii) For all taxable years beginning after December 31, 2004, amounts received by taxpayers who are or were members of the armed forces of the United States, including service in the Kansas army and air national guard, as a recruitment, sign up or retention bonus received by such taxpayer as an incentive to join, enlist or remain in the armed services of the United States, including service in the Kansas army and air national guard, and amounts received for repayment of educational or student loans incurred by or obligated to such taxpayer and received by such taxpayer as a result of such taxpayer's service in the armed forces of the United States, including service in the Kansas army and air national guard.

(xviii) For all taxable years beginning after December 31, 2004, amounts received by taxpayers who are eligible members of the Kansas army and air national guard as a reimbursement pursuant to K.S.A. 48-281, and amendments thereto, and amounts received for death benefits pursuant to K.S.A. 48-282, and amendments thereto, or pursuant to section 1 or section 2 of chapter 207 of the 2005 session laws of Kansas, and amendments thereto, to the extent that such death benefits are included in federal adjusted gross income of the taxpayer.

(xix) For the taxable year beginning after December 31, 2006, amounts received as benefits under the federal social security act which are included in federal adjusted gross income of a taxpayer with federal adjusted gross income of $50,000 or less, whether such taxpayer's filing status is single, head of household, married filing separate or married filing jointly; and for all taxable years beginning after December 31, 2007, amounts received as benefits under the federal social security act which are included in federal adjusted gross income of a taxpayer with federal adjusted gross income of $75,000 or less, whether such taxpayer's filing status is single, head of household, married filing separate or married filing jointly.

(xx) For taxable years beginning after December 31, 2008, 100% of the amount of qualified health insurance premiums to the extent the amount paid for such premiums is included in federal taxable income. The taxpayer shall provide the department of revenue with proof of the amount of qualified health insurance premiums paid. For the purposes of this provision, "qualified health insurance premium" means the amount paid during the tax year by such taxpayer for any insurance policy primarily providing health care coverage for the taxpayer, the taxpayer's spouse, or the taxpayer's dependents except that this paragraph shall not apply to any individual who claims the tax credit established in section 2

and amendments thereto.

(d) There shall be added to or subtracted from federal adjusted gross income the taxpayer's share, as beneficiary of an estate or trust, of the Kansas fiduciary adjustment determined under K.S.A. 79-32,135, and amendments thereto.

(e) The amount of modifications required to be made under this section by a partner which relates to items of income, gain, loss, deduction or credit of a partnership shall be determined under K.S.A. 79-32,131, and amendments thereto, to the extent that such items affect federal adjusted gross income of the partner.

Sec. 23. The changes to law in this act shall constitute the health care reform act of 2008.

Sec. 24. K.S.A. 21-3851, 40-2119, 40-2124, 40-2209d, 40-2209m and K.S.A. 2007 Supp. 39-709, 40-19c06, 40-2209, 40-2240, 40-3209, 65-7402, 65-7403, 75-6501, 75-7423, 75-7427 and 79-32,117 are hereby repealed.

Sec. 25. This act shall take effect and be in force from and after its publication in the statute book.