HOUSE Substitute for SENATE BILL No. 81

AN ACT enacting the health care reform act of 2008; appropriations therefor; amending K.S.A. 39-760, 40-2124, 40-2209d, 46-3001 and K.S.A. 2007 Supp. 38-2001, 40-19c06, 40-2209, 40-3209, 46-3501, 65-7402, 65-7403, 74-50,301, 74-50,302, 75-6501, 75-7401, 75-7408 and 75-7427 and repealing the existing sections.

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

New Section 1. (a) An insurer shall provide, in conjunction with a group health benefit plan, the option of establishing a premium only 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.

(c) An insurer that establishes or facilitates the establishment of a premium only cafeteria plan or other payroll deduction program pursuant to 26 U.S.C. Section 125 does not violate K.S.A. 40-2404, and amendments thereto.

(d) Nothing in this section shall be construed as prohibiting an insurer from:

(1) Charging a fee for establishing or facilitating the establishment of a premium only cafeteria plan pursuant to this section, and amendments thereto; or

(2) utilizing a vendor to facilitate the establishment of a premium only cafeteria plan pursuant to this section, and amendments thereto.

(e) The provisions of this section shall not take effect until July 1, 2008.

New Sec. 2. (a) An employer that provides health insurance coverage for which any portion of the premium is payable by an employee may also offer 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 of 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.

(d) The provisions of this section shall not take effect until July 1, 2008.

Sec. 3. On July 1, 2008, 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 sub-

scription 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 prominence 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 subjects 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. 4. On July 1, 2008, 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~~ *$2,000,000* per covered individual.

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

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

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

Sec. 5. On July 1, 2008, 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 insurer to the extent such design is not contrary to or inconsistent with this act.

(d) (1) An accident and sickness insurer offering a group policy providing hospital, medical or surgical expense benefits must renew or continue in force such coverage at the option of the policyholder or certificateholder except as provided in paragraph (2) below.

(2) An accident and sickness insurer may nonrenew or discontinue coverage under a group policy providing hospital, medical or surgical expense benefits based only on one or more of the following circumstances:

(A) If the policyholder or certificateholder has failed to pay any premium or contributions in accordance with the terms of the group policy providing hospital, medical or surgical expense benefits or the accident and sickness insurer has not received timely premium payments;

(B) if the policyholder or certificateholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of such coverage;

(C) if the policyholder or certificateholder has failed to comply with a material plan provision relating to employer contribution or group participation rules;

(D) if the accident and sickness insurer is ceasing to offer coverage in such group market in accordance with subsections (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 medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination; or (5) coverage for the employee or member, or any covered dependent thereof, was terminated for cause as permitted by the group policy or certificate of coverage approved by the commissioner. In the event the group policy is terminated and not replaced the insurer may issue an individual policy or certificate in lieu of a conversion policy or the continuation of group coverage required herein if the individual policy or certificate provides substantially similar coverage for the same or less premium as the group policy. In any event, the employee or member shall have the option to be issued a conversion policy which meets the requirements set forth in this subsection in lieu of the right to continue group coverage.

(j) The continued coverage and the issuance of a converted policy shall be subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than 31 days after termination of coverage under the group policy or not later than 31 days after notice is received pursuant to paragraph 20 of this subsection.

(2) The converted policy shall be issued without evidence of insurability.

(3) *The employer shall give the employee and such employee's covered dependents reasonable notice of the right to continuation of coverage.* The terminated employee or member shall pay to the ~~insurer~~ *employer* 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. 6. On July 1, 2008, 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. 7. On July 1, 2008, 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 marketing 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 employer shall give the employee and such employee's dependents reasonable notice of the right to continuation of coverage. The terminated employee shall pay the employer the premium for the continuation of coverage and such premium shall be the same as that applicable to members or employees remaining in the group.* 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 employee'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 con-

tained 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 copayments 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. 8. On July 1, 2008, 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 guarantee 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) *"provider-based indigent care clinic" means a clinic located in a medicare-certified hospital, nursing facility or home health agency licensed under K.S.A. 65-425 et seq., 39-923 et seq. or 65-5101 et seq., and amendments thereto, designed to provide care to the medically indigent under the medical directions of a qualified person licensed to practice medicine and surgery and licensed by the Kansas board of healing arts; and 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) "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 provider-based indigent care clinic*; and

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

Sec. 9. On July 1, 2008, 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 provider-based indigent care 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 pa-

tient 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. 10. On July 1, 2008, 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) (1) Commencing with the 2009 plan year that begins January 1, 2009, if a state employee elects the high deductible health plan and health savings account, the state's employer contribution shall equal the state's contribution to any other health benefit plan offered by the state. The cost savings to the state for the high deductible health plan shall be deposited monthly into the employee's health savings account up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended, for as long as the employee participates in the high deductible plan.

(2) If the employee had not previously participated in the state health benefits plan, the employer shall calculate the average savings to the employer of the high deductible plan compared to the other available plans and contribute that amount monthly to the employee's health savings ac-

count up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended.

(3) The employer shall allow additional voluntary contributions by the employee to their health savings account by payroll deduction up to the maximum annual amount allowed pursuant to subsection (d) of 26 U.S.C. 223, as amended.

~~(d)~~ *(e)* The commission shall have no authority to assess charges for employer contributions under the student health care benefits component 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)~~ *(f)* 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. 11. On July 1, 2008, 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 conducted 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 govern-

mental 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, has reimbursed the state of Kansas for all losses caused by the contractor, or the removal of the contractor would create a substantial loss of access for medicaid beneficiaries, in which case the authority after a specific finding to this effect may waive the prohibition of this subsection. Nothing in this section shall be construed to conflict with federal law, or to require or permit the use of federal funds where prohibited.

~~(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. 12. On July 1, 2008, K.S.A. 2007 Supp. 75-7401 is hereby amended to read as follows: 75-7401. (a) On July 1, 2005, the Kansas health policy authority is hereby established as a state agency within the executive branch of state government.

(b) The Kansas health policy authority shall be composed of nine voting members and ~~seven~~ *eight* nonvoting, ex officio members. The nine voting members shall be appointed as follows:

(1) Three members shall be appointed by the governor;

(2) two members shall be appointed by the speaker of the house of representatives;

(3) one member shall be appointed by the minority leader of the house of representatives;

(4) two members shall be appointed by the president of the senate; and

(5) one member shall be appointed by the minority leader of the senate.

(c) The ~~seven~~ *eight* nonvoting, ex officio members of the Kansas health policy authority are the director of health of the department of health and environment, secretary of health and environment, secretary of social and rehabilitation services, commissioner of insurance, secretary of administration, secretary of aging, *commissioner of education* and the executive director of the authority appointed pursuant to K.S.A. 2007 Supp. 75-7402, and amendments thereto. The ~~seven~~ *eight* nonvoting, ex officio members of the Kansas health policy authority shall act as a resource and support for the voting members of the authority and shall not be entitled to vote or to make or second motions in any meeting of the authority.

(d) The appointment of each voting member of the Kansas health policy authority shall be subject to confirmation by the senate as provided in K.S.A. 75-4315b, and amendments thereto. Except as provided by K.S.A. 46-2601, and amendments thereto, no person appointed as a voting member of the Kansas health policy authority shall exercise any power, duty or function as a member of the authority until confirmed by the senate. Each member shall hold office for a term of four years, except as provided in subsection (f) for the first members appointed to the Kansas health policy authority, and until a successor is appointed and confirmed. Terms of voting members of the Kansas health policy authority shall expire on March 15.

(e) Voting members of the Kansas health policy authority shall be members of the general public who have knowledge and demonstrated leadership in fields including, but not limited to, health care delivery, health promotion, public health improvement, evidence-based medicine, insur-

ance, information systems, data analysis, health care finance, economics, government, and business. A majority of the voting members of the Kansas health policy authority shall be Kansas residents. No member of the legislature shall be appointed as a voting member of the Kansas health policy authority.

(f) The first voting members of the Kansas health policy authority established by this section shall be appointed on or before August 1, 2005. The terms of office of such members shall be as follows:

(1) The governor shall appoint one member for a term which shall expire on March 15, 2007, and two members for a term which shall expire on March 15, 2009;

(2) the speaker of the house of representatives shall appoint two members for a term which shall expire on March 15, 2008;

(3) the minority leader of the house of representatives shall appoint one member for a term which shall expire on March 15, 2007;

(4) the president of the senate shall appoint two members for a term which shall expire on March 15, 2008; and

(5) the minority leader of the senate shall appoint one member for a term which shall expire on March 15, 2007.

In addition to such terms, each of the first members appointed shall serve until a successor is appointed and confirmed.

(g) The members of the Kansas health policy authority shall meet and organize annually by electing a voting member as chairperson, except that the governor shall designate the first chairperson of the Kansas health policy authority from among the first voting members appointed. A majority of all voting members shall constitute a quorum for meetings. All actions of the Kansas health policy authority shall be by the affirmative vote of a majority of voting members at any meeting at which a quorum is present. The Kansas health policy authority shall meet at least monthly during the fiscal year ending June 30, 2006, and thereafter not less than once per calendar quarter.

(h) Members of the Kansas health policy authority attending meetings of the authority, or attending a subcommittee meeting thereof authorized by the Kansas health policy authority, shall be paid subsistence allowances, mileage and other expenses as provided in K.S.A. 75-3212, and amendments thereto, for members of the legislature. Members on the Kansas health policy authority shall not receive compensation for their service on the authority.

(i) On July 1, 2013, the Kansas health policy authority is hereby abolished.

New Sec. 13. (a) As used in this section, "medical home" means a health care delivery model in which a patient establishes an ongoing relationship with a physician or other personal care provider in a physician-directed team, to provide comprehensive, accessible and continuous evidence-based primary and preventive care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost effective manner.

(b) The Kansas health policy authority established under K.S.A. 2007 Supp. 75-7401, and amendments thereto, shall incorporate the use of the medical home delivery system within:

(1) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. 1396 et seq., and amendments thereto;

(2) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C. 1397aa et seq., and amendments thereto; and

(3) the state mediKan program.

(c) The Kansas state employees health care commission established under K.S.A. 75-6502, and amendments thereto, shall incorporate the use of a medical home delivery system within the state health care benefits program as provided in K.S.A 75-6501 through 75-6523, and amendments thereto. Except that compliance with a medical home delivery system shall not be required of program participants receiving treatment in accordance with a religious method of healing pursuant to the provisions of K.S.A. 2007 Supp. 75-6501, and amendments thereto.

(d) On or before February 1, 2009, the Kansas health policy authority in conjunction with the department of health and environment and state stakeholders shall develop systems and standards for the implementation and administration of a medical home in Kansas.

(e) The provisions of this section shall not take effect until July 1, 2008.

Sec. 14. On July 1, 2008, K.S.A. 46-3001 is hereby amended to read as follows: 46-3001. (a) There is hereby created the joint committee on children's issues which shall be within the legislative branch of state government and which shall be composed of 10 members. Five members shall be members of the house of representatives and five members shall be members of the senate. Three of the members who are representatives shall be appointed by the speaker of the house of representatives, three members who are senators shall be appointed by the president of the senate, two members who are representatives shall be appointed by the minority leader of the house of representatives and two members who are senators shall be appointed by the minority leader of the senate. At least one member of the committee from the house of representatives shall be a member of the committee on insurance, one member shall be a member of the committee on health and human services and one member shall be a member of the committee on appropriations. At least one member of the committee from the senate shall be a member of the committee on financial institutions and insurance, one member shall be a member of the committee on public health and welfare and one member shall be a member of the committee on ways and means.

(b) All members of the joint committee on children's issues shall serve for terms of two years ending on the first day of the regular session of the legislature commencing in the first odd-numbered year after the year of appointment, except that the first members shall be appointed on the effective date of this act and shall serve for terms ending on the first day of the regular session of the legislature commencing in 1999. If a vacancy occurs in the office of any member of the joint committee on children's issues, a successor shall be appointed in the same manner as the original appointment for the remainder of the term. The chairperson shall be appointed for a term of one year which ends on the first day of the next occurring regular session of the legislature. The speaker of the house of representatives shall appoint the first chairperson on the effective date of this act and shall appoint the chairperson for the term commencing on the first day of the regular session of the legislature commencing in 1999 for a one-year term to end on the first day of the regular session of the legislature commencing in the year 2000. The president of the senate shall appoint the next chairperson on the first day of the regular session of the legislature commencing in the year 2000 for a one-year term which ends on the first day of the next occurring regular session of the legislature. Thereafter the appointment of the chairperson shall continue to alternate between the speaker of the house of representatives and the president of the senate with each subsequent chairperson being appointed for a one-year term ending on the first day of the regular session of the legislature in the next occurring regular session of the legislature after the year of appointment. If a vacancy occurs in the office of the chairperson, a member of the joint committee who is a member of the same house of the legislature as the member who vacated the office shall be appointed by the speaker of the house or president of the senate, depending on the house membership of the vacating member, to fill such vacancy.

(c) A quorum of the joint committee on children's issues shall be six. All actions of the joint committee shall be taken by a majority of all of the members of the joint committee.

(d) The joint committee on children's issues shall have the authority to meet at any time and at any place within the state on the call of the chairperson.

(e) The provisions of the acts contained in article 12 of chapter 46 of the Kansas Statutes Annotated, and amendments thereto, applicable to special committees shall apply to the joint committee on children's issues to the extent that the same do not conflict with the specific provisions of this act applicable to the joint committee.

(f) Members of the committee shall receive compensation, travel ex-

penses and subsistence expenses as provided in K.S.A. 75-3212 and amendments thereto when attending meetings of the committee.

(g) The joint committee on children's issues shall have the services of the legislative research department, the office of revisor of statutes and other central legislative staff service agencies.

(h) The joint committee on children's issues shall ~~oversee the implementation and operation of the children's health insurance plans created under the provisions of this act, including the assessment of the performance based contracting's measurable outcomes as set forth in subsection (b)(4) of K.S.A. 38-2001 and amendments thereto and other~~ *study* children's issues as the committee deems necessary.

Sec. 15. On July 1, 2008, K.S.A. 2007 Supp. 46-3501 is hereby amended to read as follows: 46-3501. (a) There is hereby created the joint committee on health policy oversight within the legislative branch of state government. The joint committee shall be composed of 12 members. Six members shall be members of the house of representatives and six members shall be members of the senate. Four of the members who are members of the house of representatives shall be appointed by the speaker of the house of representatives, four members who are senators shall be appointed by the president of the senate, two members who are members of the house of representatives shall be appointed by the minority leader of the house of representatives and two members who are senators shall be appointed by the minority leader of the senate.

(b) All members of the joint committee on health policy oversight shall serve for terms of two years ending on the first day of the regular session of the legislature commencing in the first odd-numbered year after the year of appointment, except that the first members shall be appointed on July 1, 2005, and shall serve for terms ending on the first day of the regular session of the legislature commencing in 2007. If a vacancy occurs in the office of any member of the joint committee on health policy oversight, a successor shall be appointed in the same manner as the original appointment for the remainder of the term.

(c) (1) The chairperson of the joint committee on health policy oversight shall be appointed for a term of one year which ends on the first day of the next occurring regular session of the legislature. The speaker of the house of representatives shall appoint the first chairperson on July 1, 2005, and shall appoint the chairperson for the term commencing on the first day of the regular session of the legislature commencing in 2006 for a one-year term to end on the first day of the regular session of the legislature commencing in the year 2007. The president of the senate shall appoint the next chairperson on the first day of the regular session of the legislature commencing in the year 2007 for a one-year term which ends on the first day of the next occurring regular session of the legislature. Thereafter the appointment of the chairperson shall continue to alternate between the speaker of the house of representatives and the president of the senate with each subsequent chairperson being appointed for a one-year term ending on the first day of the regular session of the legislature in the next occurring regular session of the legislature after the year of appointment.

(2) The vice-chairperson of the joint committee on health policy oversight shall be appointed for a term of one year which ends on the first day of the next occurring regular session of the legislature. The president of the senate shall appoint the first vice-chairperson on July 1, 2005, and shall appoint the vice-chairperson for the term commencing on the first day of the regular session of the legislature commencing in 2006 for a one-year term to end on the first day of the regular session of the legislature commencing in the year 2007. The speaker of the house of representatives shall appoint the next vice-chairperson on the first day of the regular session of the legislature commencing in the year 2007 for a one-year term which ends on the first day of the next occurring regular session of the legislature. Thereafter the appointment of the vice-chairperson shall continue to alternate between the speaker of the house of representatives and the president of the senate with each subsequent vice-chairperson being appointed for a one-year term ending on the first day of the regular session of the legislature in the next occurring regular session of the legislature after the year of appointment.

(3) If a vacancy occurs in the office of the chairperson or vice-chair-

person, a member of the joint committee on health policy oversight who is a member of the same house of the legislature as the member who vacated the office shall be appointed by the speaker of the house, if the vacating member was a member of the house of representatives, or by the president of the senate, if the vacating member was a member of the senate, to fill such vacancy.

(d) A quorum of the joint committee on health policy oversight shall be seven. All actions of the joint committee on health policy oversight shall be taken by a majority of all of the members of the joint committee.

(e) The joint committee on health policy oversight shall have the authority to meet at any time and at any place within the state on the call of the chairperson.

(f) The provisions of the acts contained in article 12 of chapter 46 of the Kansas Statutes Annotated, and amendments thereto, applicable to special committees shall apply to the joint committee on health policy oversight to the extent that the same do not conflict with the specific provisions of this section applicable to the joint committee.

(g) Members of the joint committee on health policy oversight shall receive compensation, travel expenses and subsistence expenses as provided in K.S.A. 75-3212 and amendments thereto when attending meetings of the joint committee.

(h) The staff of the legislative research department, the office of revisor of statutes and the division of legislative administrative services shall provide such assistance as may be requested by the joint committee on health policy oversight and to the extent authorized by the legislative coordinating council.

(i) The joint committee on health policy oversight shall have the exclusive responsibility to monitor and study the operations and decisions of the Kansas health policy authority. *In addition, the joint committee shall oversee the implementation and operation of the children's health insurance plans, including the assessment of the performance based contracting's measurable outcomes as set forth in subsection (b)(4) of K.S.A. 38-2001, and amendments thereto.*

(j) In accordance with K.S.A. 46-1204 and amendments thereto, the legislative coordinating council may provide for such professional services as may be requested by the joint committee on health policy oversight.

(k) The joint committee on health policy oversight may introduce such legislation as it deems necessary in performing its functions.

(l) The provisions of this section shall expire on July 1, 2013.

Sec. 16. On July 1, 2008, K.S.A. 2007 Supp. 74-50,301 is hereby amended to read as follows: 74-50,301. (a) In order to encourage and to expand the use of cafeteria plans authorized by 26 U.S.C. 125, by small employers, there is hereby established the small employer cafeteria plan development program.

(b) Subject to the provisions of appropriations acts and in accordance with the provisions of this act, the ~~secretary of the department of commerce~~ *Kansas health policy authority* may provide grants to small employers for the purpose of establishing a cafeteria plan authorized by 26 U.S.C. 125. The provisions of this section shall not apply to any small employer who has a cafeteria plan established prior to the effective date of this act.

(c) The ~~secretary of commerce~~ *Kansas health policy authority* shall develop and implement marketing strategies to ensure that small employers are aware of the state program and to demonstrate the benefits of establishing a cafeteria plan to both the employer and employee.

(d) The ~~secretary of commerce~~ *Kansas health policy authority* may contract with third party administrators of cafeteria plans authorized by 26 U.S.C. 125, for the purpose of helping in the development and implementation of the provisions of this section.

(e) There is hereby established in the state treasury the small employer cafeteria plan development program fund. The ~~secretary of commerce~~ *Kansas health policy authority* shall administer such fund and expenditures from the small employer cafeteria plan development program fund for the purpose of providing grants in accordance with this section. All expenditures from the small employer cafeteria plan development program fund shall be made in accordance with appropriations acts upon warrants of the director of accounts and reports issued pursuant to vouch-

ers approved by the ~~secretary of commerce~~ *Kansas health policy authority* or the designee of the ~~secretary~~ *authority*.

(f) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the small employer cafeteria plan development program fund interest earnings based on:

(1) The average daily balance of moneys in the small employer cafeteria plan development program fund for the preceding month; and

(2) the net earnings rate for the pooled money investment portfolio for the preceding month.

(g) For the purpose of this section "small employer" means any employer that employs 50 or less employees.

(h) The ~~secretary of commerce~~ *Kansas health policy authority* may adopt rules and regulations to implement the provisions of this section.

(i) The provisions of this section shall expire on July 1, 2009.

Sec. 17. On July 1, 2008, K.S.A. 2007 Supp. 74-50,302 is hereby amended to read as follows: 74-50,302. (a) The ~~secretary of commerce~~ *Kansas health policy authority* is hereby authorized to make grants or no interest loans for the purpose of financing the initial costs associated with the forming and organizing of associations to assist members of the association to obtain access to quality and affordable health care plans. Such grants or loans may be used to pay for actuarial or feasibility studies.

(b) Such grants and loans shall be made upon such terms and conditions as the ~~secretary of commerce~~ *Kansas health policy authority* may deem appropriate, except that: (1) Such loans shall be made interest free and with recourse, and (2) the association shall provide a match for such grant or loan. Such grants and loans shall be made from funds credited to the association assistance plan fund.

(c) There is hereby established in the state treasury the association assistance plan fund. The ~~secretary of commerce~~ *Kansas health policy authority* shall administer such fund and expenditures from the association assistance plan fund for the purpose of providing grants and no interest loans in accordance with this section. All expenditures from the association assistance plan fund shall be made in accordance with appropriation acts upon warrants of the director of accounts and reports issued pursuant to vouchers approved by the ~~secretary of commerce~~ *Kansas health policy authority* or the designee of the ~~secretary~~ *authority*.

(d) On July 1, 2007, the director of accounts and reports shall transfer $500,000 from the state general fund to the association assistance plan fund.

(e) On or before the 10th day of each month, the director of accounts and reports shall transfer from the state general fund to the association assistance plan fund interest earnings based on:

(1) The average daily balance of moneys in the association assistance plan fund for the preceding month; and

(2) the net earnings rate for the pooled money investment portfolio for the preceding month.

(f) For the purpose of this section:

(1) "Association" means a small business or an organization of persons having a common interest; and

(2) "small business" means any business that employs 50 or less employees.

(g) The ~~secretary of commerce~~ *Kansas health policy authority* may adopt rules and regulations to implement the provisions of this section.

(h) Any health care plans offered through any association funded in whole or in part with grants or loans pursuant to this section shall be underwritten by an insurance company or health maintenance organization that holds a valid Kansas certificate of authority as verified by the commissioner of insurance and any such association shall be subject to the provisions of K.S.A. 40-2209, 40-2209a through 40-2209p and 40-2222, and amendments thereto.

New Sec. 18. The changes to law in this act shall constitute the health care reform act of 2008.

New Sec. 19. The Kansas health policy authority shall, subject to appropriations, establish and implement the following:

(a) Dental coverage for pregnant medicaid beneficiaries the cost of which shall not exceed $545,833;

(b) expansion of medicaid eligibility up to 200% of the federal poverty level and smoking cessation programs for pregnant women, the cost of which will be approximately $460,000 from the state general fund;

(c) the statewide community health records program, the cost of which shall not exceed $383,600.

(d) The provisions of this section shall not take effect until July 1, 2008.

New Sec. 20. (a) The department of health and environment shall, subject to appropriations, establish a program to increase access to screenings for colon, breast, prostate and cervical cancer, to be used in conjunction with, but not limited to, rural health clinics and safety net clinics, the cost of which shall not exceed $1,500,000.

(b) The provisions of this section shall not take effect until July 1, 2008.

Sec. 21. On July 1, 2008, K.S.A. 39-760 is hereby amended to read as follows: 39-760. (a) The *Kansas health policy authority and the* secretary of social and rehabilitation services ~~is~~ *are* hereby directed to establish a system for the reporting of suspected abuse or fraud in connection with state welfare or medical assistance programs, either by recipients or health care providers. The system shall be designed to permit any person in the state at any time to place a toll-free call into the system and report suspected cases of welfare abuse or suspected cases of health care provider fraud.

(b) The *Kansas health policy authority and the* secretary of social and rehabilitation services ~~is~~ *are* further directed to publicize the system throughout the state.

(c) Notice of the existence of the system established pursuant to this section shall be displayed prominently in the office or facility of every health care provider who provides services under the state medical assistance program.

(d) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall notify ~~monthly~~ *annually* each recipient of state medical assistance of the toll-free number of the system established pursuant to this section and the purpose thereof. If possible, such notice shall be printed on the medical cards issued to recipients by the ~~secretary~~ *authority*.

Sec. 22. On July 1, 2008, K.S.A. 2007 Supp. 38-2001 is hereby amended to read as follows: 38-2001. (a) The ~~secretary of social and rehabilitation services~~ *Kansas health policy authority* shall develop and submit a plan consistent with federal guidelines established under section 4901 of public law 105-33 (42 U.S.C. 1397aa et seq.; title XXI).

(b) The plan developed under subsection (a) shall be a capitated managed care plan covering Kansas children from zero to 19 years which:

(1) Contains benefit levels at least equal to those for the early and periodic screening, diagnosis and treatment program;

(2) provides for presumptive eligibility for children where applicable;

(3) provides continuous eligibility for 12 months once a formal determination is made that a child is eligible subject to subsection (e);

(4) has performance based contracting with measurable outcomes indicating age appropriate utilization of plan services to include, but not limited to, such measurable services as immunizations, vision, hearing and dental exams, emergency room utilization, annual physical exams and asthma;

(5) shall use the same prior authorization standards and requirements as used for health care services under medicaid to further the goal of seamlessness of coverage between the two programs; ~~and~~

(6) ~~will~~ *shall* provide targeted low-income children, as defined under section 4901 of public law 105-33 (42 U.S.C. 1397aa, et seq.), coverage subject to appropriations~~.~~*;*

(7) shall provide coverage, subject to appropriation of funds and eligibility requirements, for children residing in a household having a gross household income (A) for 2009, at or under 225% of the 2008 federal poverty income guidelines and (B) for 2010 and subsequent years, at or under 250% of the 2008 federal poverty income guidelines; the participants receiving coverage shall contribute to the payment for such coverage through a sliding-fee scale based upon ability to pay as established by rules and regulations of the Kansas health policy authority; and

(8) contains a provision which requires the newly enrolled participants with a family income over 200% of the federal poverty income guidelines

to wait at least 8 months before participating in this program, if such participants previously had comprehensive health benefit coverage through an individual policy or a health benefit plan provided by any health insurer as defined in K.S.A. 40-4602, and amendments thereto. This waiting period provision shall not apply when the prior coverage ended due to loss of employment other than the voluntary termination, change to a new employer that does not provide an option for dependent coverage, discontinuation of health benefits to all employees, expiration of COBRA coverage period or any other situations where the prior coverage ended due to reasons unrelated to the availability of this program.

(c) The ~~secretary~~ *Kansas health policy authority* is authorized to contract with entities authorized to transact health insurance business in this state to implement the health insurance coverage plan pursuant to subsection (a) providing for several plan options to enrollees which are coordinated with federal and state child health care programs, except that when contracting to provide managed mental health care services the ~~secretary~~ *Kansas health polity authority* shall assure that contracted entities demonstrate the ability to provide a full array of mental health services in accordance with the early and periodic screening, diagnosis and treatment plan. The ~~secretary~~ *Kansas health policy authority* shall not develop a request for proposal process which excludes community mental health centers from the opportunity to bid for managed mental health care services.

(d) When developing and implementing the plan in subsection (a), the ~~secretary~~ *Kansas health policy authority* to the extent authorized by law:

(1) Shall include provisions that encourage contracting insurers to utilize and coordinate with existing community health care institutions and providers;

(2) may work with public health care providers and other community resources to provide educational programs promoting healthy lifestyles and appropriate use of the plan's health services;

(3) shall plan for outreach and maximum enrollment of eligible children through cooperation with local health departments, schools, child care facilities and other community institutions and providers;

(4) shall provide for a simplified enrollment plan;

(5) shall provide cost sharing as allowed by law;

(6) shall not count the caring program for children, the Kansas health insurance association plan or any charity health care plan as insurance under subsection (e)(1);

(7) may provide for payment of health insurance premiums, including contributions to a ~~medical~~ *health* savings account if applicable, *and, in conjunction with an employer sponsored insurance premium assistance plan, may provide that supplemental benefits be purchased outside of the capitated managed care plan,* if it is determined cost effective, taking into account the number of children to be served and the benefits to be provided; ~~and~~

(8) may provide that prescription drugs, transportation services and dental services are purchased outside of the capitated managed care plan to improve the efficiency, accessibility and effectiveness of the program~~.~~*; and*

(9) shall include a provision that requires any individual to be a citizen or an alien lawfully admitted to the United States for purposes of establishing eligibility for benefits under the plan and to present satisfactory documentary evidence of citizenship or lawful admission of the individual. The criteria for determining whether the documentation is satisfactory shall be no more restrictive than the criteria used by the social security administration to determine citizenship. A document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe, such as a tribal enrollment card or certificate of degree of Indian blood shall be satisfactory documentary evidence of citizenship or lawful admission.

(e) A child shall not be eligible for coverage and shall lose coverage under the plan developed under subsection (a) of K.S.A. 38-2001, and amendments thereto, if such child's family has not paid the enrollee's applicable share of any premium due.

If the family pays all of the delinquent premiums owed during the year, such child will again be eligible for coverage for the remaining months of the continuous eligibility period.

(f) The plan developed under section 4901 of public law 105-33 (42 U.S.C. 1397aa et seq., and amendments thereto) is not an entitlement program. The availability of the plan benefits shall be subject to funds appropriated. The ~~secretary~~ *Kansas health policy authority* shall not utilize waiting lists, but shall monitor costs of the program and make necessary adjustments to stay within the program's appropriations.

(g) Eligibility and benefits under the plan prescribed by subsection (b)(7) are not and shall not be construed to be entitlements, are for legal residents of the state of Kansas and are subject to availability of state and federal funds and to any state and federal requirements and the provisions of appropriation acts. If the Kansas health policy authority determines that the available federal funds and the state funds appropriated are insufficient to sustain coverage for the income eligibility levels prescribed by subsection (b)(7), a lower income level shall be adopted and implemented by the Kansas health policy authority, within the limits of appropriations available therefor, and all such changes shall be published by the Kansas health policy authority in the Kansas register.

Sec. 23. On July 1, 2008, K.S.A. 2007 Supp. 75-7408 is hereby amended to read as follows: 75-7408. (a) On and after July 1, 2006, the Kansas health policy authority shall coordinate health care planning, administration, and purchasing and analysis of health data for the state of Kansas with respect to the following health programs administered by the state of Kansas:

(1) Developing, implementing, and administering programs that provide medical assistance, health insurance programs, or waivers granted thereunder for persons who are needy, uninsured, or both, and that are financed by federal funds or state funds, or both, including the following:

(A) The Kansas program of medical assistance established in accordance with title XIX of the federal social security act, 42 U.S.C. § 1396 et seq., and amendments thereto;

(B) the health benefits program for children established under K.S.A. 38-2001 et seq., and amendments thereto, and developed and submitted in accordance with federal guidelines established under title XXI of the federal social security act, section 4901 of public law 105-33, 42 U.S.C. § 1397aa et seq., and amendments thereto;

(C) any program of medical assistance for needy persons financed by state funds only, to the extent appropriations are made for such a program;

(D) the working healthy portion of the ticket to work program under the federal work incentive improvement act and the medicaid infrastructure grants received for the working healthy portion of the ticket to work program; *and*

(E) the medicaid management information system (MMIS); ~~and~~

~~(F) a phased-in premium assistance plan to assist eligible low income Kansas residents with the purchase of private insurance or other benefits that are actuarially equivalent to the Kansas state employee health plan under a program authorized under subsection (a)(1). In program years one and two, subject to appropriation of funds and other eligibility requirements, eligible participants shall consist of families at and under 50% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year three shall consist of families at and under 75% of the federal poverty level. Subject to appropriation of funds and other eligibility requirements, eligible participants in program year four shall consist of families at and under 100% of the federal poverty level. The Kansas health policy authority is authorized to seek any approval from the centers for medicare and medicaid services necessary to accomplish the development or expansion of premium assistance programs for families;~~

(2) the restrictive drug formulary, the drug utilization review program, including oversight of the medicaid drug utilization review board, and the electronic claims management system as provided in K.S.A. 39-7,116 through 39-7,121 and K.S.A. 2007 Supp. 39-7,121a through 39-7,121e, and amendments thereto; and

(3) administering any other health programs delegated to the Kansas health policy authority by the governor or by a contract with another state agency.

(b) Except to the extent required by its single state agency role as

designated in K.S.A. 2007 Supp. 75-7409, and amendments thereto, or as otherwise provided pursuant to this act the Kansas health policy authority shall not be responsible for health care planning, administration, purchasing and data with respect to the following:

(1) The mental health reform act, K.S.A. 39-1601 et seq., and amendments thereto;

(2) the developmental disabilities reform act, K.S.A. 39-1801 et seq., and amendments thereto;

(3) the mental health program of the state of Kansas as prescribed under K.S.A. 75-3304a, and amendments thereto;

(4) the addiction and prevention services prescribed under K.S.A. 65-4001 et seq., and amendments thereto; or

(5) any institution, as defined in K.S.A. 76-12a01, and amendments thereto.

Sec. 24.

DEPARTMENT OF HEALTH AND ENVIRONMENT—
DIVISION OF HEALTH

(a) The legislature, acting during the 2008 regular session, adopts the following specific recommendations providing funding for the following priorities for fiscal year 2009:

Primary care safety net clinics $2,500,000

Sec. 25.

UNIVERSITY OF KANSAS MEDICAL CENTER

(a) There is appropriated for the above agency from the state general fund for the fiscal year or years specified, the following:

Wichita center for graduate medical education
For the fiscal year ending June 30, 2009..... $1,500,000

Provided, That $7,100,000 has been requested by the Wichita center for graduate medical education from the Kansas bioscience authority for research-oriented grant funding: *Provided further*, That expenditures shall be made from the Wichita center for graduate medical education account for purposes of funding non-research needs such as offsite or rural rotation for which medicare funding has been terminated or for purposes of attaining adequate standard for accreditation of the WCGME residency program.

New Sec. 26. (a) There is hereby established the physician workforce and accreditation task force, which is referred to in this section as the task force. The task force shall be composed of 12 members appointed as follows: (1) Two members who are members of the medical faculty or administrators of the school of medicine of the university of Kansas medical center, of which one member shall be from the Kansas City campus and one member shall be from the Wichita campus, who shall be appointed by the dean of the school of medicine of the university of Kansas medical center; (2) two members who are practicing medicine in Kansas and are current or former participants in a Kansas graduate medical residency program who shall be appointed by the governor; (3) one member who shall be appointed by the state board of regents; (4) one member who is representative of the Via Christi Regional Medical Center who shall be appointed by the governing body of the Wichita Center for Graduate Medical Education; (5) one member who is representative of the Wesley Medical Center who shall be appointed by the governing body of the Wichita Center for Graduate Medical Education; (6) one member who shall be appointed by the Kansas health policy authority; (7) one member who is an administrator of a rural hospital who shall be appointed by the Kansas hospital association; (8) one member who is a legislator who shall be appointed by the president of the senate; (9) one member who is a legislator who shall be appointed by the speaker of the house of representatives; (10) one member who is a legislator who shall be appointed by the minority leader of the senate; and (11) one member who is a legislator who shall be appointed by the minority leader of the house of representatives.

(b) The speaker of the house of representatives shall designate one member to serve as chairperson of the task force and the president of the senate shall designate one member to serve as the vice-chairperson of the task force. The task force shall meet on call of the chairperson or on the

request of seven members of the task force, subject to approval by the legislative coordinating council.

(c) Seven members of the task force shall constitute a quorum. All actions of the task force shall be taken by a majority of all members of the task force.

(d) The task force shall study and adopt recommendations regarding the physician work force and accreditation issues, including: (1) How best to maintain accreditation of graduate medical education programs sponsored by the university of Kansas school of medicine in Kansas City and Wichita, with special attention to maintaining the existing partnerships with Via Christi Regional Medical Center, Wesley Medical Center and the university of Kansas medical center - Wichita; (2) recommendations for the necessary and appropriate level of funding for graduate medical education sponsored by the university of Kansas; (3) alternative means of obtaining such funding; and (4) a strategic plan to accomplish such matters.

(e) The task force shall report its findings and recommendations to the committee on ways and means of the senate and the committee on appropriations of the house of representatives prior to the beginning of the 2009 regular session of the legislature.

(f) The staff of the office of the revisor of statutes, the legislative research department and the division of legislative administrative services shall provide such assistance as may be requested by the task force and authorized by the legislative coordinating council.

New Sec. 27. (a) The Kansas health policy authority, subject to appropriations, may establish a pilot program implementing access to care programs for outreach to increase enrollment of children in medicaid and healthwave with priority given to rural and safety net clinics, the cost of which shall not exceed $550,000 per year.

(b) The Kansas health policy authority shall report its findings and any recommendations which the Kansas health policy authority may have concerning the pilot program established under this section to the governor, the joint committee on health policy oversight and the legislature annually.

(c) The provisions of this section shall expire on July 1, 2010.

(d) The provisions of this section shall not take effect until July 1, 2008.

Sec. 28. On July 1, 2008, K.S.A. 39-760, 40-2124, 40-2209d, 46-3001 and K.S.A. 2007 Supp. 38-2001, 40-19c06, 40-2209, 40-3209, 46-3501, 65-7402, 65-7403, 74-50,301, 74-50,302, 75-6501, 75-7401, 75-7408 and 75-7427 are hereby repealed.

Sec. 29. This act shall take effect and be in force from and after its publication in the Kansas register.

I hereby certify that the above BILL originated in the SENATE, and passed that body

_____

SENATE adopted
Conference Committee Report _____

_____
President of the Senate.

_____
Secretary of the Senate.

Passed the HOUSE
as amended _____

HOUSE adopted
Conference Committee Report _____

_____
Speaker of the House.

_____
Chief Clerk of the House.

APPROVED _____

_____
Governor.