Approved: Jan. 24, 1994
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson William Bryant at 3:30 p.m. on January 19, 1994 in Room 527-S of the Capitol.

All members were present except: Representative Galen Weiland, Excused

Committee staff present: William Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Dick Brock, Insurance Department
Chip Wheelen, Kansas Medical Society
Robert Epps, SRS

Others attending: See attached list

Chairman Bryant announced that the hearing on HB 2636 would be moved to Tuesday, January 25 and the bills heard today would be worked on Thursday, January 20.

Hearing on HB 2617: An act relating to accident and sickness insurance; discontinuance of certain contracts

Dick Brock, Insurance Commissioner's office, appeared before the Committee in support of the proposed legislation via balloon amendment (Attachment 1). Health insurance companies many times introduce a new policy form and market it for several years or until the claims experience begins to require upward premium adjustments. When the company reaches the point that it is no longer competitive, the company will introduce a new policy, case marketing the previous one and sell the new product only to persons who meet certain underwriting criteria. Insurees with a health condition who do not qualify for the new policy have little choice but to remain insured under the policy originally purchased until the premium level reaches the point that it is unaffordable. This process recycles thus leaving consumers with unaffordable insurance premiums or no insurance at all. This bill would alleviate the problem in two ways:

1. Require an insurer who stops marketing a particular policy form to permit any existing policy holder to purchase any other product being sold by the company that provides comparable benefits, services and terms.

2. Require the insurer to pool the claims experience developed by a closed block of business with the claims experience of all comparable blocks of business still being marketed for the purpose of determining the premium for contracts within the closed block.

Hearing on HB 2618: An act relating to accident and sickness insurance; discontinuance of certain contracts

Dick Brock, Insurance Commissioner's Office, stated that this bill was a product of an Insurance Department task force of 1993. Problems have arisen for health policy holders due to language regarding benefits to be paid for usual, reasonable and customary charges. This term does not mean the insurer will pay whatever the attending health care provider or health care facility charges less any applicable deductible and co-payment. Neither does it mean there is one standard amount that is applied to any given procedure in any given situation. The task force recommends the schedule for quantifying the usual and customary charge in a given situation be that of the Prevailing Healthcare Charges System (PHCS) established and sold by the Health Insurance Association of America. (Attachment 2)

Chip Wheelen, Kansas Medical Society, testified in support of the bill as the proposed amendment would establish fairness in determining what is the usual, customary, and reasonable fee or charge for a specific service or procedures (Attachment 3).

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE, Room 527-S Statehouse, at 3:30 p.m. on January 19, 1994.

Committee members made inquiries regarding balance billing, participating provider coverage, consumer awareness of co-payment requirements and charges.

Hearing on HB 2632: An act relating to insurance; underwriting, assignment of rights, application to medicaid eligibility and coverage

Robert Epps, SRS, explained that this bill would place the following into Kansas law in order to comply with the recent federally mandated requirements contained in OBRA of 1993 (Attachment 4):

1. Specific language to apply OBRA 93 requirements to self-funded, self-administrated health benefit plans, previously exempt from any State control (ERISA).

2. Prohibit the consideration of Medicaid benefits in the issuing, coverage or payment of benefits under any health insurance policy or benefit plan.

3. Establish and preserve the Medicaid program's rights of subrogation to the extent benefits were provided by the program.

Dick Brock stated that the bill would (Attachment 5):

1. Prohibit insurance companies, HMO's, nonprofit medical, hospital, dental, optometric and pharmacy corporations and self-insured plans from refusing to provide, continue to provide, limit, or charge a different rate for health insurance solely because of eligibility for Medicaid.

2. Prohibit the imposition of requirement relating to the assignment of benefits that are different for persons covered by or eligible for Medicaid than those applicable to any other individual.

3. Prohibit the exclusion, limitation or other restrictions of coverage under private insurance plans because Medicaid benefits may be available for the same injury or sickness.

Hearing on HB 2619: Nonduplication of workers compensation benefits

Dick Brock stated that this bill is another product of the insurance task force (Attachment 6). The proposal related to the exclusion contained in most, if not all, health insurance contracts which precludes the payment of health insurance benefits if workers compensation coverage is available. The proposed legislation would impose language which makes the exclusion operable only if workers compensation benefits actually are or will be received.

The meeting adjourned at 4:50 p.m. The next meeting is scheduled for January 20, 1994.

GUEST LIST

COMMITTEE: House Fin & Ed DATE: 1-19-94

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATI
David Hanson	Topeka	KS Life Assoc
Bill Sneed	Topeka	KFRA
Dick Brock	"	Insurance Dept.
Rowbritzler	"	"
Harry Spring	K.C.	Humana
Ross FREY	Topeka	KVMA
Joe Fuquay	Topeka	KCA
Brad Smoot	BCBS Topeka	BCBS
[illegible]	Topeka	SRS
Charles Walker	Topeka	SRS
BRENT DOANE	WICHITA	KAHSB

Testimony on

House Bill No. 2617

by

Dick Brock

Kansas Insurance Department

House Bill No. 2617 is directed toward a problem encountered by health insurance consumers when the insurance company that issued their policy stops selling that particular form and begins marketing a new product. This is a tool used by many insurers to maintain competitively priced products and thereby attract new business.

Generally, the way it seems to work is that an insurance company will introduce a new policy form, market it for several years or until the claims experience begins to require upward premium adjustments. When the premium level reaches the point that it is no longer competitive, the company will introduce a new policy, cease marketing the previous one and sell the new product only to persons who meet certain underwriting criteria. This means that persons with a health condition or who do not otherwise qualify for the new policy have little choice but to remain insured under the policy originally purchased until the premium level reaches the point that it is unaffordable. Meanwhile, those insured under the new policy being marketed grow older, experience health problems and their premiums begin to rise. When the premiums under that policy reach the limit of being competitive, that block of business is closed and the process starts over.

House Bill No. 2617 would impose 2 requirements that should alleviate this problem and probably even stop the practice. First, if an insurer stops marketing a particular policy form, it would be required to permit any existing policyholder to purchase any other product being sold by the company that provides comparable benefits, services and terms. Second, the proposal would require the insurer to pool the claims experience developed by a closed block of business with the claims experience of all comparable blocks of business still being marketed for the purpose of determining the premium for contracts within the closed block. As a result, persons can

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retain coverage under the original contract then purchased yet pay premiums that are based on the combined experience of all those similarly insured.

The one aspect of this proposal I want to note in addition to the foregoing is that its provisions would apply only on a prospective basis. Section 1(a) provides that its provisions do not apply to any block of business already in force in Kansas on the effective date of the law. This legislation was the third recommendation to emerge from the Individual Health Insurance Task Force previously referenced and its prospective application was suggested by that body. As I understand it, the concern about possible retroactive application of the requirements stems from the fact that current premium levels for both closed and open blocks of business were developed with the understanding that the premium levels could be independently adjusted. As a result, the premium levels for the open blocks of business do not contemplate either a sudden influx of insured risks that do not meet current underwriting standards or a subsidization of the premium for those remaining in a closed block. This seems to be a reasonable position but is worthy of special mention.

Session of 1994

HOUSE BILL No. 2617

By Committee on Financial Institutions and Insurance

1-13

AN ACT relating to accident and sickness insurance; discontinuance of certain contracts.

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

Section 1. (a) This act shall apply to individual contracts covering hospital, medical or surgical expenses, which are issued, amended, delivered or renewed on or after the effective date of this act.

providing long term care coverage, and medicare supplement policies

(b) As used in this act:

(1) "Block of business" means a particular individual policy form or contract providing hospital, medical or surgical expense coverage issued by a carrier to one or more individuals which includes distinct benefits, services and terms.

long term care, or medicare supplement

(2) "Closed block of business" means a block of business which a carrier ceases to actively offer or sell to new applicants.

(3) "Carrier" means any insurance company, nonprofit medical and hospital service corporation, ~~nonprofit optometric, dental or 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 any individual hospital, surgical or medical expense policy and which is authorized to do business in this state. "Carrier" does not include those entities identified above with respect to the sale or issuance of policies or certificates covering only accident, credit, dental, disability income, ~~long term care,~~ hospital indemnity, medicare supplement, specified disease ~~or~~, vision care coverage issued as a supplement ~~of~~ 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.

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

(c) No block of business shall be closed by a carrier unless:

(1) The carrier permits existing contractholders to purchase a contract from any block of business that is not closed and which provides comparable benefits, services and terms, with no additional underwriting requirement or waiting period; and

(2) the carrier pools the experience of the closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any contract within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool.

(d) A block of business shall be presumed closed if either of the following circumstances exist:

(1) There has been an overall reduction in that block of 12% in the number of in-force contracts for a period of 12 months; or

(2) that block has less than 500 in-force contracts in this state.

The presumption that applies in the circumstances of subsection (d)(2) shall not apply to a block of business initiated within the previous 24 months, but notification of that block of business shall be provided to the commissioner pursuant to subsection (e).

The fact that a block of business does not meet one of the presumptions set forth in this subsection shall not preclude a determination that it is closed as defined in paragraph (2) of subsection (b).

(e) A carrier shall notify the commissioner in writing within 30 days of its decision to close a block of business or, in the absence of an actual decision to close a block of business, within 30 days of its determination that a block of business is within one of the presumptions set forth in subsection (d). When the carrier decides to close a block of business, the written notice shall fully disclose all information required for compliance with subsection (c). When the carrier determines that a block of business is within a presumption of subsection (c), the written notice shall fully disclose all information required for compliance with a presumption of subsection (c). In the case of either notice, the carrier shall provide additional information within 15 business days after a request by the commissioner.

(f) A carrier shall preserve for a period of not less than five years in an identified location which is readily accessible for review by the commissioner, all books and records relating to any action taken by a carrier pursuant to subsection (c).

(g) No carrier shall offer or sell any contract, or provide misleading information about the active or closed status of a block of business, for the purpose of evading this act.

Sec. 2. This act shall take effect and be in force from and after its publication in the statute book.

Testimony on
House Bill No. 2618
by
Dick Brock
Kansas Insurance Department

House Bill No. 2618 is one of the products of an Insurance Department task force that was created in early summer of 1993 to review the individual health insurance environment in Kansas to determine what, if any, of the recent insurance reforms enacted and implemented with respect to group health insurance should be applied to the individual health insurance market. A copy of the task force report to the Commissioner which summarizes the task force discussions is available and will be provided to anyone interested in its content.

House Bill No. 2618 addresses a frequent problem encountered by health insurance policyholders and beneficiaries when benefits are to be paid on the basis of usual, reasonable and customary charges. These problems arise from the fact that this language or this term does not mean the insurer will pay whatever the attending health care provider or health care facility charges less any applicable deductible and copayment. Neither does it mean there is one standard amount that is applied to any given procedure in any given situation.

It is, of course, not an issue with respect to services performed pursuant to a pre-arranged contract between the health care provider and third party payor, particularly those that prohibit balance billing. Rather, the difficulties stem from traditional insurance or indemnity products which simply provide for the payment of reasonable, usual and customary charges without further definition of specificity.

Based on the task force discussion of this issue, it appears the predominant basis for quantifying the usual and customary charge in a given situation is the Prevailing Healthcare Charges System (PHCS) established and sold by the Health Insurance Association of America. The schedule is developed by means

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of a statistical sample of actual claims arranged in percentiles by procedure by geographic area. The documentation and information acquired through the task force review further seemed to confirm that the PHCS was based on a valid statistical base and would produce reliable results by geographic area.

Difficulties arise, however, from the fact that insurers are not required to rely on PHCS or any other recognized array of charge information. In fact, some insurers appear to rely on a unique schedule or schedules the origin of which is unknown. In addition, even insurers utilizing PHCS calculate their actual payments on a percentile basis. Therefore, some insurers may allow benefits for a covered medical service at the 70th percentile of the PHCS schedule while others may pay at the 80th or 90th percentile. This, of course, creates a disparity because different insureds and different providers receive different benefits/payments for the same service based on the same schedule. The issue is further complicated by the argument that payment at the 100% level of the PHCS would encourage price increases on the part of providers whereas varying allowances at lower amounts makes it difficult to target the upper limit.

From an insurance company perspective, the current system is probably satisfactory. However, from a public interest viewpoint, the determination of usual, reasonable and customary charges is, at best, inconsistent and, at worst, a scheme that permits an intentional underpayment of claims. House Bill No. 2618 is at least a first step toward improving this process from the consumers' perspective.

The proposal itself avoids the problems associated with a uniform standard that cannot possibly recognize the innumerable differences between one medical case and another yet assures the "usual, customary and reasonable" charge data is developed on a credible basis. In addition, it provides the Commissioner and insureds a proper foundation for regulatory or legal action when and if the need arises.

As indicated earlier, House Bill No. 2618 may not be the ultimate solution to this problem but we believe it is a good first step.

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

January 19, 1994

To: House Committee on Financial Institutions and Insurance

From: Chip Wheelen, KMS Director of Public Affairs

Subject: House Bill 2618 as Introduced; Payment of Benefits under Health Insurance Policies

The Kansas Medical Society supports the provisions of HB 2618. The amendment to current law would establish fairness in determining what is the usual, customary, and reasonable fee or charge for a specific service or procedure.

Oftentimes, an insurer will require that physicians sign a participation agreement (contract) in order to be eligible for assignment of benefits by the patient. This is done primarily for the convenience of patients because otherwise, the patient would need to afford the initial cash expenditure until he or she could obtain a reimbursement from the insurer. The assignment of benefits to the provider of care has become the norm rather than the exception. Frequently, the patient will select his or her provider based upon whether the provider is listed as participating in the insurance plan.

When a physician signs a participation agreement, he or she is normally required to accept either a schedule of fees which stipulate the amount of payment, or agree to accept the usual, customary, and reasonable payment for services. Because physicians are prohibited by federal anti-trust laws from collectively discussing their fees, it is not possible for them to determine what is in fact usual, customary, and reasonable. The result can be a dispute as to whether the insurer's determination of usual, customary, and reasonable is indeed reasonable.

The new language in paragraph (8) would require insurers to use statistically sound methods to determine what is the usual, customary, and reasonable payment for a specified service or procedure. The reference to "codes and nomenclature developed and maintained by recognized authorities" is also important for purposes of standardizing health insurance claims payment.

Thank you for considering our concerns regarding this matter. We respectfully request that you recommend passage of HB 2618.

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KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Donna L. Whiteman, Secretary

House Committee on Financial Institutions and Insurance
Testimony on HB 2632
January 19, 1994

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The SRS Mission Statement:
"The Kansas Department of Social and Rehabilitation Services empowers individuals and families to achieve and sustain independence and to participate in the rights, responsibilities and benefits of full citizenship by creating conditions and opportunities for change, by advocating for human dignity and worth, and by providing care, safety and support in collaboration with others."

****

Mr. Chairman, Members of the Committee, on behalf of Secretary Whiteman, I thank you for this opportunity to address you on House Bill 2632. The Department supports this legislation and cooperated with the Kansas Insurance Department in drafting the original proposal. House Bill 2632 seeks to place into Kansas law recent federally mandated requirements contained in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93). The requirements of OBRA 93 that are applied to this legislation include: 1) specific language to apply OBRA 93 requirements to self-funded, self-administrated health benefit plans, previously exempt from any State control, 2) prohibit the consideration of Medicaid benefits in the issuing, coverage or payment of benefits under any health insurance policy or benefit plan, 3) establish and preserve the Medicaid program's rights of subrogation to the extent benefits were provided by the program.

Under provisions of OBRA 93, Kansas has until April 1, 1994 to pass legislation implementing the requirements of the Act. Failure to do so would render our State Plan for Medical Assistance out of compliance with federal law and result in the reduction of federal matching funds for the operation of the Kansas Medicaid Program. Currently, 60% of the Medicaid funding is received as federal matching funds. Even a small reduction in that amount would severely restrict, the provision of basic health care to the needy in Kansas.

The Department of Social and Rehabilitation Services urges passage of House Bill 2632, as proposed, in an expeditious manner to meet the April 1, 1994 deadline.

Robert L. Epps
Commissioner
Income Support/Medical Services
(913) 296-6750

FI & I
Attachment 4
Jan 19, 1994

SEC. 13623. LIABILITY OF THIRD PARTIES TO PAY FOR CARE AND SERVICES.

#1 *(a) LIABILITY OF ERISA PLANS.—(1) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)) is amended by striking "insurers)" and inserting "insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations)".*

(2) Section 1903(o) (42 U.S.C. 1396b(o)) is amended by striking "regulation)" and inserting "regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974)), a service benefit plan, and a health maintenance organization)".

#2 *(b) REQUIRING STATE TO PROHIBIT INSURERS FROM TAKING MEDICAID STATUS INTO ACCOUNT.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—*

(1) by striking "and" at the end of subparagraph (F);

(2) by adding "and" at the end of subparagraph (G); and

(3) by adding after subparagraph (G) the following new subparagraph:

"(H) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;".

#3 *(c) STATE RIGHT TO THIRD PARTY PAYMENTS.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)), as amended by subsection (b), is amended—*

(1) by striking "and" at the end of subparagraph (G);

(2) by adding "and" at the end of subparagraph (H); and

(3) by adding after subparagraph (H) the following new subparagraph:

"(I) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;".

(d) EFFECTIVE DATES.—(1) Except as provided in paragraph (2), the amendments made by subsections (a)(1), (b), and (c) shall apply to calendar quarters beginning on or after October 1, 1993, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsections (a) and (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the preceding sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(3) The amendment made by subsection (a)(2) shall apply to items and services furnished on or after October 1, 1993.

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Testimony on
House Bill No. 2632
by
Dick Brock
Kansas Insurance Department

The federal Omnibus Budget Reconciliation Act (OBRA) of 1993 requires states to have various statutory provisions in place by April 1, 1994 or face possible loss of federal Medicaid matching funds. The Insurance Department worked with the Department of Social and Rehabilitation Services to develop this proposal. The conferee from that agency is much more conversant with the federal requirement than I; however, the substantive provisions are in Section 1 and can be summarized as follows.

First, it would prohibit insurance companies, HMOs, nonprofit medical, hospital, dental, optometric and pharmacy corporations and self-insured plans from refusing to provide, continue to provide, limit, or charge a different rate for health insurance solely because of eligibility for Medicaid.

Second, it prohibits the imposition of requirements relating to the assignment of benefits that are different for persons covered by or eligible for Medicaid than those applicable to any other individual.

Third, it prohibits the exclusion, limitation or other restrictions of coverage under private insurance plans because Medicaid benefits may be available for the same injury or sickness.

Sections 2, 3, 4 and 5 are technical amendments that are necessary to make the provisions applicable to the various mutual nonprofit service corporations authorized under Kansas law.

Section 6 simply repeals the statutes being amended and Section 7 provides for the bill to become effective upon publication in the Kansas Register in an effort to satisfy the April 1 deadline in the federal legislation.

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Testimony on

House Bill No. 2619

by

Dick Brock

Kansas Insurance Department

House Bill No. 2619 is another product of the individual health insurance task force described in the testimony on House Bill No. 2619. This proposal relates to the exclusion contained in most, if not all, health insurance contracts which precludes the payment of health insurance benefits if workers compensation coverage is available.

In its policy form approval process, Kansas does not permit the use of vague or indefinite terms in these exclusions such as "eligible for workers compensation", "workers compensation benefits that may be payable" etc. Rather, an effort is made during the policy review to obtain language which makes the exclusion operable only if workers compensation benefits actually are or will be received.

To the extent abuse would otherwise exist, the Department's administrative action is generally sufficient. However, the possibility exists that an insurer may be using an unfiled policy form, the contract may have been issued in another state or for some other reason the exclusionary language is not properly worded.

The difficulty inherent in an exclusion that is too broad usually is revealed in cases involving sole proprietors, partners, agricultural workers and others who are not required to be covered by the Kansas workers compensation law but may elect to come under its provisions. The exclusion used by some insurers presumes that most or all employee/employer work-related injuries fall within the purview of workers compensation but, in Kansas, this is an incorrect presumption. As a result, the exclusion language needs to be more narrowly drawn than is apparently necessary in some states.

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Therefore, House Bill No. 2619 would simply codify the Department's administrative requirement so that even if a given contract contains an objectionable version of the exclusion, the statutory provision would prevail. In addition, insurers would generally be more aware of the Kansas requirement.

or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

~~(E)~~ *(e) Third-party ownership:* The word "insured," as used in this act, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

~~(F)~~ *(f) Requirements of other jurisdictions:* (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this act and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer, when issued for delivery in any other state or country, may contain any provision permitted or required by the laws of such other state or country.

~~(G)~~ *(g) Filing procedure:* The commissioner of insurance may ~~make~~ *adopt* such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this act as are necessary, proper or advisable to the administration of this act. This provision shall not abridge any other authority granted the commissioner of insurance by law.

~~(H)~~ *(h)* (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.

Sec. ~~2.~~ K.S.A. 40-2203 is hereby repealed.

Sec. ~~3.~~ This act shall take effect and be in force from and after its publication in the statute book.

New Sec. 2. No policy of accident and sickness insurance delivered or issued for delivery in this state shall contain any provision excluding or restricting coverage due to benefits which may be provided pursuant to K.S.A. 44-501 et seq. unless such benefits are actually paid or payable to the person covered by the accident and sickness insurance policy.

3.

4.