CONFERENCE COMMITTEE REPORT

MR. PRESIDENT and MR. SPEAKER: Your committee on conference on Senate amendments to **HB 2075** submits the following report:

The House accedes to all Senate amendments to the bill, and your committee on conference further agrees to amend the bill as printed with Senate Committee of the Whole amendments, as follows:

On page 2, by striking all in lines 42 and 43;

By striking all on pages 3 through 31;

On page 32, by striking all in lines 1 through 20 and inserting "Section 1. From and after July 1, 2011, K.S.A. 2010 Supp. 40-433 is hereby amended to read as follows: 40-433. No policy of group life insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued by an insurance company organized under the laws of the state of Kansas on its employees and agents, which agents for the purpose of this act only shall be deemed employees, the beneficiaries under such policies to be persons designated by each insured, or a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, both subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors or partnerships if the business of the employer and of such affiliated corporations, proprietors or partnerships is under common control through

stock ownership, contract or otherwise. The policy may provide that the term "employees" shall include the individual proprietor or partners if the employer is an individual proprietor or a partnership. The policy may provide that the term "employees" shall include retired employees. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless the proprietor or partner is actively engaged in and devotes a substantial part of their time to the conduct of the business of the proprietor or partnership. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(b) The premium for the policy ~~shall~~may be paid by the policyholder, either wholly from the employer's funds or funds contributed by the employer, or partly from such funds and partly from funds contributed by the insured employees~~. No policy shall be issued on which the entire premium is to be derived from funds contributed by the insured employees. A policy on which part of the premium is to be derived from funds contributed by the insured employees may be placed in force only if at least 75% of the then eligible employees, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contribution~~or entirely by the employees at their option. A policy on which no part of the premium is to be derived from funds contributed by the insured employees shall insure all eligible employees, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer or except those who reject the coverage in writing.

(c) ~~The policy shall cover at least two employees at date of issue. (d)~~ The amounts of insurance under the policy shall be based upon some plan, precluding individual selection either

by the employees or by the employer or trustees.

(2) 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 thereof 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. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors shall not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least 75% of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of such identifiable charges shall insure all eligible debtors, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(c) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly, or may reasonably be expected to receive at least 100 new entrants during the first policy year, and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than 75% of the new entrants become insured.

(d) The amount of insurance on the life of any debtor shall at no time exceed the amount owed by that debtor which is repayable in installments to the creditor.

(e) The insurance shall be payable to the policyholder. Such payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of such payment.

(3) A policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives or agents, subject to the following requirements:

(a) The members eligible for insurance under the policy shall be all of the members of the union, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the union, or both.

(b) The premium for the policy ~~shall~~may be paid by the policyholder, either wholly from the union's funds, or partly from such funds and partly from funds contributed by the insured members specifically for their insurance or entirely by the insured members at their option. ~~No policy shall be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least 75% of the then eligible members excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions.~~ A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance shall insure all eligible members, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer or except those who reject coverage in writing.

(c) ~~The policy shall cover at least 25 members at date of issue.~~

~~(d)~~ The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the members or by the union.

(4) A policy issued to the trustees of a fund established in this state by two or more employers if a majority of the employees to be insured of each employer are located within the state, or to the trustees of a fund established by one or more labor unions, or by one or more employers and one or more labor unions, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(a) The persons eligible for insurance shall be all of the employees of the employers or all of the members of the unions, or all of any class or classes thereof determined by conditions pertaining to their employment, or to membership in the unions, or to both. The policy may provide that the term "employees" shall include retired employees and the individual proprietor or partners if any employer is an individual proprietor or a partnership. No director of a corporate employer shall be eligible for insurance under the policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director. No individual proprietor or partner shall be eligible for insurance under the policy unless the proprietor or partner is actively engaged in and devotes a substantial part of their time to the conduct of the business of the 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.

(b) The premium for the policy ~~shall~~may be paid by the trustees either wholly from funds contributed by the employer or employers of the insured persons, or by the union or unions, or by both, or partly from such funds and partly from funds contributed by the insured employees or wholly from funds contributed by the employees or members at their option. ~~No policy shall be issued on which the entire premium is to be derived from funds contributed by the insured~~

~~persons.~~ The policy shall insure all eligible persons, or all except any as to whom evidence of individual insurability is not satisfactory to the insurer or except those who reject coverage in writing.

(c) ~~The policy shall cover at date of issue at least 100 persons and not less than an average of five persons per employer unit. (d)~~ The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers~~,~~ or union.

~~(e) The requirements of paragraphs (b) and (d) of this subsection governing employer contributions and amounts of insurance shall not apply to a voluntary term life insurance policy issued on a group basis.~~

(5) A policy issued to an association which has been organized and is maintained for 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" as used herein shall be deemed to 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. The amounts of insurance under the policy shall be based upon some plan precluding individual selection either by the insured person or by the association or by the member.

(6) Any policy issued pursuant to this section may be extended to insure the employees against loss due to the death of their spouses, their children, their grandchildren, their spouse's children, their spouse's grandchildren, their parents, their spouse's parents, or any class or classes thereof, subject to the following requirements:

(a) The premium for the insurance ~~shall~~may be paid by the policyholder, either from the employer's funds or from funds contributed by the insured employees, or from both. ~~If any part of the premium is to be derived from funds contributed by the insured employees, the insurance with respect to spouses, their children, their grandchildren, their spouse's children, their spouse's grandchildren, their parents and their spouse's parents may be placed in force only if at least 75% of the then eligible employees, excluding any as to whose family members' evidence of insurability is not satisfactory to the insurer, elect to make the required contribution.~~ If no part of the premium is to be derived from funds contributed by the employees, all eligible employees, excluding any as to whose family members' evidence of insurability is not satisfactory to the insurer, shall be insured with respect to their spouses, their children, their grandchildren, their spouse's children, their spouse's grandchildren, their parents, their spouse's parents.

~~(b) The amounts of insurance shall be based upon some plan precluding individual selection either by the employees or by the policyholder, or employer and shall not exceed with respect to any spouse, child or parent 50% of the insurance on the life of such insured employee.~~

~~(c)~~ (b) Upon termination of the insurance with respect to the spouse of an employee by reason of the employee's termination of employment or death, the spouse insured pursuant to this section shall have the same conversion rights as to the insurance on such spouse's life as is provided for the employee under K.S.A. 40-434, and amendments thereto.

~~(d)~~ (c) Notwithstanding the provisions of K.S.A. 40-434, and amendments thereto only one certificate need be issued for delivery to an insured person if a statement concerning any dependent's coverage is included in such certificate.

~~(e) The requirements of paragraphs (a) and (b) of this subsection governing participation, contribution by an employer and amounts of insurance for dependents shall not apply to a~~

~~voluntary term life insurance policy issued on a group basis.~~

(7) A policy may be issued to any other group which the commissioner of insurance finds is the proper subject of a group life insurance policy or contract. Any such group shall be subject to any appropriate conditions or provisions relating thereto which the commissioner may establish or require, consistent with the provisions of this act, and such conditions and provisions shall be included in the policy or contract.

Sec. 2. From and after July 1, 2011, K.S.A. 40-22a13 is hereby amended to read as follows: 40-22a13. On and after ~~January 1, 2000~~July 1, 2011, for the purposes of K.S.A. 40-22a13 through 40-22a16, and amendments thereto:

(a) "Adverse decision" means a utilization review determination by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and~~,~~*:*

(1) If the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services~~,~~*;* or

(2) the adverse decision is the reason for the insured not receiving the requested services.

(b) "Emergency medical condition" means:

(1) The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy~~.~~*;*

(2) a medical condition where the time frame for completion of a standard external review

would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or

(3) a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

(c) "External review organization" means an entity that conducts independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall have experience serving as the external quality review organization in health programs administered by the state of Kansas, or be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event no Kansas providers are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in such health care provider's practice outside the state of Kansas.

(d) "Health insurance plan" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans.

(e) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group-funded pool, and the self-funded coverage established by the state of Kansas, or

any hospital or medical expense, health, hospital or medical service corporation contract or a plan provided by a municipal group-funded pool.

(f) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group-funded pool and the self-funded coverage established by the state of Kansas for its employees.

Sec. 3. From and after July 1, 2011, K.S.A. 40-22a14 is hereby amended to read as follows: 40-22a14. On and after ~~January 1, 2000~~July 1, 2011:

(a) The provisions of K.S.A. 40-22a13 through 40-22a16, and amendments thereto, shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issues as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

(b) The right to external review under K.S.A. 40-22a13 through 40-22a16, and amendments thereto, shall not be construed to change the terms of coverage under a health insurance plan or insurance policy.

(c) The insurer or health insurance plan shall provide written notice to the insured of a final adverse decision and the opportunity for requesting an external review.

(d) (1) The insured has the right to request an independent external review of an adverse decision by a health insurance plan or insurer when:

~~(1)~~(A) The insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has an emergency medical condition, in which case an expedited procedure is used; or

~~(2)~~(B) the insured has not received a final decision from the insurer within 60 days of seeking the internal review, except to the extent that the delay was requested by the insured.

(2) Whenever an insurer or health insurance plan fails to strictly adhere to all appeal procedure requirements as prescribed by state or federal law, the claimant shall be deemed to have exhausted the internal claims and appeal process regardless of whether such insurer or health insurance plan asserts that:

(A) It has substantially complied with such appeal procedure; or

(B) any error it committed was de minimis.

(e) Within ~~90~~120 days of receipt of an adverse decision by a health insurance plan or an insurer, any request for external review shall be made in writing to the commissioner from the following persons: (1) The insured; (2) the treating physician or health care provider acting on behalf ~~on~~of the insured with written authorization from the insured; or (3) a legally authorized designee of the insured.

(f) The insured shall provide all information in the possession of the insured pertaining to the adverse decision in order for the commissioner to make a preliminary determination for an external review. The insured also shall provide the commissioner with an appeal form, and a fully executed release for the commissioner and the external review organization to obtain any necessary medical records from the insurer or health insurance plan and any other relevant

provider.

(g) In responding to the commissioner, the insurer or health insurance plan shall provide a copy of the adverse decision given to the insured and all medical and other records pertaining to the insured's claim within five business days of the request of the commissioner.

(h) The confidentiality of any medical information submitted by the insured, on behalf of the insured, insurer or health insurance plan, shall be maintained pursuant to applicable state and federal laws.

Sec. 4. From and after July 1, 2011, K.S.A. 40-22a15 is hereby amended to read as follows: 40-22a15. On and after ~~January 1, 2000~~July 1, 2011:

(a) The commissioner shall:

(1) Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health insurance plan or insurer;

(2) allow the insurer or the health insurance plan, an insured or treating physician or health care provider acting on behalf of the insured, or legally authorized designee filing a request for external review to provide additional written information as may be relevant for the commissioner to make a final decision on whether the request qualified for external review;

(3) make a decision on a request for external review within 10 business days after receiving all necessary information;

(4) notify the insured and treating physician or health care provider acting on behalf of the insured, or legally authorized designee, and insurer or health insurance plan in writing that a request for external review will or will not be granted; and

(5) design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision.

(b) The external review organization as defined in subsection (c) of K.S.A. 40-22a13, and amendments thereto, shall provide that all reviews completed pursuant to K.S.A. 40-22a13 through 40-22a16, and amendments thereto, are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the performance of the external review organization's duties in K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(c) The external review organization shall issue a written decision to the insured and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within 30 business days. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review shall be whether the health care service denied by the insurer or health insurance plan was covered or excluded from coverage under the terms of the insured's contract.

(d) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues ~~within seven business days~~not more than 72 hours after the date of receipt of the request for an expedited external review, or as expeditiously as the insured’s medical condition or circumstances require.

(e) The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

(f) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured, health insurance plan or insurer for any opinion rendered as part of an external review conducted pursuant to K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(g) The external review organization shall maintain confidentiality of the medical records of the insured in accordance to state and federal law.

(h) The external review organization's fee for performance of any external review may be paid by the commissioner, the insurer or the health insurance plan. In no event shall the insured be held responsible for any portion of such fee.

Sec. 5. From and after July 1, 2011, K.S.A. 40-22a16 is hereby amended to read as follows: 40-22a16. On and after ~~January 1, 2000~~ July 1, 2011:

(a) The decision of the external review organization may be reviewed directly by the district court at the request of either the insured, insurer or health insurance plan. The review by the district court shall be *de novo*. The decision of the external review organization shall not preclude the insured, insurer or health insurance plan from exercising other available remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the insured, insurer or health insurance plan after the decision of the external review organization will not stay the external review organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation.

(b) In no event shall more than one external review be available ~~during the same year~~ for any request arising out of the same set of facts during a period of 12 consecutive months commencing on the date of the initial request for external review. An insured may not pursue, either concurrently or sequentially, an external review process under both a federal and state law. ~~In the event external review processes are available pursuant to federal law and this act, the~~

~~insured shall have the option of designating which external review process will be utilized.~~

(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(d) The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of K.S.A. 40-22a13 through 40-22a16, and amendments thereto. The rules and regulations shall ensure that the commissioner is able to provide for an effective and efficient external review of health care services.

(e) Except as provided in subsection (a), the decision of the external review organization shall be binding on the insured and the insurer or health insurance plan.

Sec. 6. K.S.A. 2010 Supp. 40-2122 is hereby amended to read as follows: 40-2122. (a) The following individuals shall be eligible for plan coverage provided they meet the criteria set forth in subsection (b):

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

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

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

(4) any federally defined eligible individual for FTAA.

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

(1) Such person has had health insurance coverage involuntarily terminated for any reason

other than nonpayment of premium;

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

(3) Such person is a child under the age of 19 years and has been unable to purchase or obtain coverage under an individual health insurance policy providing health insurance coverage, because such coverage is not available for sale in the county in which the child resides;

~~(3)~~ (4) such person has applied for health insurance and has been quoted a premium rate which is in excess of the plan rate;

~~(4)~~ (5) such person has been accepted for health insurance subject to a permanent exclusion of a preexisting disease or medical condition;

~~(5)~~ (6) such person is a federally defined eligible individual; or

~~(6)~~ (7) such person is a federally defined eligible individual for FTAA.

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

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

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

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

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

(4) any person having access to accident and health insurance through an employer-

sponsored group or self-insured plan, including coverage under the consolidated omnibus budget reconciliation act (COBRA), except that the requirement for exhaustion of any available COBRA or state continuation is waived whenever such person:

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

(B) has three months of prior creditable coverage as described in subsection (c) of K.S.A. 40-2124, and amendments thereto; or

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

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

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

Sec. 7. K.S.A. 2010 Supp. 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. 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) *C*overage under the plan shall be subject to a maximum lifetime benefit of ~~$2,000,000~~ $3,000,000 per covered individual.

(c) 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 either 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 or an individual under the age of 19 years who is eligible for enrollment in the plan under paragraph (3) of subsection (b) of K.S.A. 40-2122, and amendments thereto. For any individual who is eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986, the preexisting conditions limitation will not apply whenever such individual has maintained creditable health insurance coverage for an aggregate period of three months, not counting any period prior to a 63-day break in coverage, as of the date on which such individual seeks to enroll in coverage provided by this act.

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

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

New Sec. 8. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization, municipal group-funded pool and the state employee health care benefits plan which is delivered, issued for delivery, amended or renewed on or after July 1, 2011, shall exclude coverage for elective abortions, unless the procedure is necessary to preserve the life of the mother. Coverage for abortions may be obtained through an optional rider for which an additional premium is paid. The premium for the optional rider shall be calculated so that it fully covers the estimated cost of covering elective abortions per enrollee as determined on an average actuarial basis.

(b) No health insurance exchange established within this state or any health insurance exchange administered by the federal government or its agencies within this state shall offer health insurance contracts, plans, or policies that provide coverage for elective abortions, nor shall any health insurance exchange operating within this state offer coverage for elective abortions through the purchase of an optional rider.

(c) For the purposes of this section:

(1) "Abortion" means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and

which causes the premature termination of the pregnancy.

(2) "Elective" means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.

(d) The provisions of this section shall be effective from and after July 1, 2011.

Sec. 9. From and after July 1, 2011, K.S.A. 2010 Supp. 40-2,103 is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114, 40-2,160, 40-2,165 through 40-2,170, inclusive, 40-2250, K.S.A. 2010 Supp. 40-2,105a, 40-2,105b ~~and~~, 40-2,184 and section 8, and amendments thereto, shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 10. From and after July 1, 2011, K.S.A. 2010 Supp. 40-19c09 is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service corporation act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, and amendments thereto, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 through 40-2,170, inclusive, 40-2a01 et seq., 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-

2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 2010 Supp. 40-2,105a, 40-2,105b ~~and~~, 40-2,184 and section 8, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation 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.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

New Sec. 11. From and after July 1, 2011, any provisions of section 8 and amendments thereto, or the application thereof to any person or circumstances is held invalid, the invalidity shall not affect other provisions or applications of such section which can be given effect without the invalid provisions or application, and to this end, the provisions of section 8, and amendments thereto, are severable.

Sec. 12. From and after July, 1, 2011, K.S.A. 40-22a13, 40-22a14, 40-22a15 and 40-22a16 and K.S.A. 2010 Supp. 40-433, 40-2,103 and 40-19c09 are hereby repealed.

Sec. 13. K.S.A. 40-2122 and 40-2124 are hereby repealed.

Sec. 14. This act shall take effect and be in force from and after its publication in the Kansas register.";

On page 1, in the title, by striking all in lines 3 through 7 and inserting:

"AN ACT concerning insurance; pertaining to review of healthcare decisions; pertaining to group life insurance; excluding insurance coverage for certain abortions; pertaining to the Kansas

uninsurable health plan act; amending K.S.A. 40-22a13, 40-22a14, 40-22a15 and 40-22a16 and K.S.A. 2010 Supp. 40-2,103, 40-433, 40-19c09, 40-2122 and 40-2124 and repealing the existing sections.";

And your committee on conference recommends the adoption of this report.

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Conferees on part of Senate

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Conferees on part of House