40-2118. Uninsurable health insurance plan; definitions. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

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

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

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

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

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

(f) "Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:

(1) A group health plan;

(2) health insurance coverage;

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

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

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

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

(7) a state health benefit risk pool;

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

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

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

(11) a state children's health insurance program established pursuant to title XXI of the Social Security Act.

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

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

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

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

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

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

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

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

(1) Legally domiciled in this state; and

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

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

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

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

(n) "Health insurance" means any hospital or medical expense policy, health, hospital or medical service corporation contract, and a plan provided by a municipal group-funded pool, or a health maintenance organization contract offered by an employer or any certificate issued under any such policies, contracts or plans. "Health insurance" does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

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

(s) "Medicare" means coverage under both parts A and B of title XVIII of the federal social security act, 42 U.S.C. § 1395.

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

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

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

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

History: L. 1992, ch. 209, § 2; L. 1997, ch. 190, § 7; L. 1999, ch. 106, § 1; L. 2004, ch. 159, § 8; L. 2010, ch. 108, § 2; July 1.