2021 Kansas Statutes

40-2209d. Same; definitions. As used in the small employer health insurance availability 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 in chapter 40 of the Kansas Statutes Annotated, and amendments thereto, 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, a plan provided by a municipal group-funded pool, or 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. § 125 that 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. § 223, and any regulations promulgated thereunder. "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" means the same as in 26 U.S.C. § 223(d).

(n) "High deductible health plan" means a policy or contract of health insurance or health care plan that meets the criteria established in 26 U.S.C. § 223(c) and any regulations promulgated thereunder.

(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.

(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.

(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.

(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.
(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.
(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.
(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.
(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.
(w) "Small employer" means any person, firm, corporation or partnership eligible for group sickness and accident insurance pursuant to 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, employees participating in an association health plan shall be counted in the aggregate at the association level. Also in determining the number of eligible employees companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer. Except as otherwise specifically provided, the provisions of the small employer health insurance availability act apply to a small employer that 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.
(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.
(y) "Association health plan" or "AHP" means a coverage for the payment of expenses described in K.S.A. 40-2222, and amendments thereto, offered by a qualified trade, merchant, retail or professional association or business league that complies with the provisions of K.S.A. 40-2222a and 40-2222b, and amendments thereto.
(z) "Qualified trade, merchant, retail or professional association or business league" means any bona fide trade merchant, retail or professional association or business league that: (1) Has been in existence for at least five calendar years; (2) is comprised of five or more employers; and (3) is incorporated in this state, has a principal office located in this state, or has a principal office within a metropolitan area that has boundaries within this state.
History: L. 1992, ch. 200, § 3; L. 1994, ch. 355, § 4; L. 1996, ch. 182, § 7; L. 1997, ch. 190, § 2; L. 1998, ch. 174, § 6; L. 2008, ch. 164, § 6; L. 2019, ch. 54, § 10; May 9.