Session of 2009

HOUSE BILL No. 2286

By Committee on Health and Human Services

2-5

AN ACT concerning insurance; pertaining to practices affecting certain individual policies; amending K.S.A. 40-2257 and K.S.A. 2008 Supp. 40-2215 and repealing the existing sections.

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

Section 1. K.S.A. 2008 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) No individual policy of accident and sickness insurance as defined in K.S.A. 40-2201 and amendments thereto shall be issued or delivered to any person in this state nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto, have been filed with the commissioner of insurance.

(b) No group or blanket policy or certificate of accident and sickness insurance providing hospital, medical or surgical expense benefits shall be issued or delivered to any person in this state, nor shall any application, rider or endorsement be used in connection therewith, until a copy of the form thereof and of the classification of risks and the premium rates pertaining thereto has been filed with the commissioner of insurance.

(c) (1) No such policy shall be issued, nor shall any application, rider or endorsement be used in connection therewith, until the expiration of 30 days after it has been filed unless the commissioner gives written approval thereof.

(2) (A) The commissioner shall create a requirements document containing filing requirements for each type of insurance. Such requirements document shall contain a list of all product filing requirements for each type of insurance that is required to be filed. For each type of insurance, such requirements document shall contain an appropriate citation to each requirement contained in any statute, rule and regulation and published bulletins in this state having the force and effect of law. Such requirements document shall be available on the insurance department internet website.

(B) The commissioner shall update the requirements document referred to in subparagraph (A) no less frequently than annually. The commissioner shall update the requirements document referred to in subparagraph (A) within 30 days after the effective date of any change in law,

rule and regulation or bulletin published by the commissioner having the force and effect of law in this state.

(3) A filer shall submit with each policy form filing a document indicating the location within the policy form or any supplemental document for information establishing compliance with each requirement contained in the requirements documents referenced in subparagraph (A) of paragraph (2) of this subsection. A filer shall certify that the policy form, including any accompanying supplemental document, meets all requirements of state law.

(d) (1) Any risk classifications, premium rates, rating formulae, and all modifications thereof applicable to Kansas residents shall not establish an unreasonable, excessive or unfairly discriminatory rate or, with respect to group or blanket sickness and accident policies providing hospital, medical or surgical expense benefits issued pursuant to K.S.A. 40-2209 or 40-2210, and amendments thereto, discriminate against any individuals eligible for participation in a group, or establish rating classifications within a group that are based on medical conditions. In no event shall the rates charged to any group to which this subsection applies increase by more than 75% during any annual period unless the insurer can clearly document a material and significant change in the risk characteristics of the group.

(2) All rates for sickness and accident insurance providing hospital, medical or surgical expense benefits covering Kansas residents shall be made in accordance with the following provisions and due consideration shall be given to:

(A) Past and prospective loss experience;

(B) past and prospective expenses;

(C) adequate contingency reserves; and

(D) all other relevant factors within and without the state.

(3) Nothing in this act is intended to prohibit or discourage reasonable competition or discourage or prohibit uniformity of rates except to the extent necessary to accomplish the aforementioned purpose. The commissioner is hereby authorized to issue such rules and regulations as are necessary and not inconsistent with this act.

(e) Notwithstanding the provisions of subsection (d), premium rates may be used upon filing with the insurance department of a policy form if the filing is accompanied by the policy form filing and a minimum loss ratio guarantee. Insurers may use the filing procedure specified in this subsection only if the affected policy forms disclose the benefit of a minimum loss ratio guarantee. An insurer may not elect to use the filing procedure in this subsection for a policy form that does not contain the minimum loss ratio guarantee. If an insurer elects to use the filing procedure in this subsection for a policy form or forms, the insurer shall not

use a filing of premium rates that does not provide a minimum loss ratio guarantee for that policy form or forms.

(1) The minimum loss ratio shall be in writing and shall contain at least the following:

(A) An actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subsection;

(B) a statement certifying that all rates, fees, dues and other charges are not excessive, inadequate or unfairly discriminatory;

(C) detailed experience information concerning the policy forms;

(D) a step-by-step description of the process used to develop the experience loss ratio, including demonstration with supporting data;

(E) a guarantee of a specific lifetime minimum loss ratio, that shall be greater than or equal to the following:

(i) 60% for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers; and

(ii) 65% for policies issued to small groups of two to 50 employees or for certificates issued to members of an association that offers coverage to small employers;

(F) a guarantee that the actual Kansas loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards referred to in paragraph (5), adjusted for duration;

(G) a guarantee that the actual Kansas lifetime loss ratio shall meet or exceed the minimum loss ratio standards referred to in paragraph (5); and

(H) if the annual earned premium volume in Kansas under the particular policy form is less than $2,500,000, the minimum loss ratio guarantee shall be based partially on the Kansas earned premium and other credibility factors as specified by the insurance commissioner.

(2) The actual Kansas minimum loss ratio results for each year at issue shall be independently audited at the insurer's expense and the audit shall be filed with the insurance commissioner not later than 120 days after the end of the year at issue.

(3) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio.

(4) A Kansas policyholder affected by the guaranteed minimum loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund shall be made to all Kansas policyholders insured under the applicable policy form during the year at issue if the refund would equal $10 or more per policy. The refund shall include statutory interest from July 1 of the year at issue until the date of payment. Payment shall be made not later than 180 days after the end of the year

at issue.

(5) Premium refunds of less than $10 per insured must be credited to the policyholder's account.

(6) No provision of paragraphs (2) and (3) shall apply if premium rates are filed with the insurance department and accompanied by a minimum loss ratio guarantee that meets the requirements of this subsection. Such filings shall be deemed approved. Each insurer paying a risk assessment may include the amount of the assessment in establishing premium rates filed with the insurance commissioner under this section. The insurer shall identify any assessment allocated.

(7) The policy form filing of an insurer using the filing procedure with a minimum loss ratio guarantee will disclose to the enrollee, member or subscriber an explanation of the lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(8) The insurer who elects to use the filing procedure with a minimum loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests and an explanation of amounts less than $10.

~~(e)~~ *(f)* All parties in the filing process shall act in good faith and with due diligence in performance of their duties pursuant to this section.

~~(f)~~ *(g)* (1) Within 30 days of receipt of the initial filing, the commissioner shall review and approve such filing or provide notice of any deficiency or disapprove the initial filing. Any notice of deficiency or disapproval shall be in writing and based only on the specific provisions of applicable statutes, regulations or bulletins published by the commissioner having the force and effect of law in this state and contained in the requirements document created by the commissioner pursuant to subparagraph (A) of paragraph (2) of subsection (c). The notice of deficiency or disapproval shall provide specific reasons for notice of deficiencies or disapproval. Such reasons shall contain sufficient detail for the filer to bring the policy form into compliance, and shall cite each specific statute, rule and regulation or bulletin having the force and effect of law in this state upon which the notice of deficiency or disapproval is based. Any notice of disapproval provided by the commissioner shall state that a hearing will be granted within 20 days after receipt of a written request therefor by the insurer. At the end of the 30 day period, the policy form shall be deemed approved if the commissioner has taken no action.

(2) In addition to the statutes, regulations or bulletins described in paragraph (2) of subsection (c), the commissioner may disapprove a filing or provide a notice of deficiency for any form for which the commissioner determines that the benefits provided therein are unreasonable in relation to the premium charged; or if such form contains any provisions which

are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of such policy. Any notice of disapproval provided by the commissioner pursuant to this paragraph shall state that a hearing will be granted within 20 days after receipt of a written request therefor by the insurer.

(3) If the insurer has received a disapproval or notice of deficiency or disapproval regarding a policy form, it shall be unlawful for an insurer to issue such policy form or use such policy form in connection with any policy until that policy form has received a later approval by the commissioner.

(4) Within 30 days of receipt of the commissioner's notice of deficiency or disapproval, a filer may resubmit a policy form that corrects any deficiencies or resubmit a disapproved policy form and a revised certification. Any policy form not resubmitted to the commissioner within 30 days of the notice of deficiency shall be deemed withdrawn. Any disapproved policy form not resubmitted to the commissioner within 30 days of the notice of disapproval shall be deemed disapproved.

(5) (A) Within 30 days of receipt of a resubmitted filing and certification, the commissioner shall review the resubmitted filing and certification, and shall approve or disapprove such resubmitted filing and certification. Any notice of disapproval pertaining to the resubmitted filing and certification shall be in writing and provide a detailed description of the reasons for the disapproval in sufficient detail for the filer to bring the policy form into compliance. The notice of disapproval shall cite each specific statute, rule and regulation or bulletin having the force and effect of law in this state upon which the disapproval is based. No further extension of time may be taken unless the filer has introduced new provisions in the resubmitted filing and certification or the filer has materially modified any substantive provisions of the policy form, in which case the commissioner may extend the time for review by an additional 30 days. At the end of this 30 day review period, the policy form shall be deemed approved if the commissioner has taken no action.

(B) (i) Subject to clause (ii) of this subparagraph, the commissioner may not disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to paragraph (1) of this subsection.

(ii) The commissioner may disapprove a resubmitted policy form for reasons other than those initially set forth in the original notice of deficiencies or disapproval sent pursuant to this subsection if:

(a) The filer has introduced new provisions in the resubmitted policy form and certification;

(b) the filer has materially modified any substantive provisions of the policy form;

(c) there has been a change in any statute, rule and regulation or published bulletin in this state having the force and effect of law; or

(d) there has been reviewer error and the written disapproval fails to state a specific provision of applicable statute, regulation or bulletin published by the commissioner having the force and effect of law in this state that is necessary to have the policy form conform to the requirements of law.

(6) At the end of the review period, the policy form shall be deemed approved if the commissioner has taken no action.

(7) Notwithstanding any other provision in this section, the commissioner may return a grossly inadequate filing to the filer without triggering any of the time deadlines set forth in this section. For purposes of this paragraph, the term "grossly inadequate filing" means a filing that fails to provide key information, including state-specific information, regarding a product, policy or rate, or that demonstrates an insufficient understanding of what is required to comply with state statutes or regulations.

~~(g)~~ *(h)* Except in cases of a material error or omission in a policy form that has been approved or deemed approved pursuant to the provisions of this act, the commissioner shall not:

(1) Retroactively disapprove that filing; or

(2) with respect to those policy forms, examine the filer during a routine or targeted market conduct examination for compliance with any later-enacted policy form filing requirements.

~~(h)~~ *(i)* If a rate filing or marketing material is required to be filed or approved by state law for a specific policy form, the time frames for review, approval or disapproval, resubmission, and re-review of those rate filings or marketing materials shall be the same as those provided for in subsection ~~(f)~~ *(g)* for the review of policy forms.

~~(i)~~ *(j)* For purposes of this section:

(1) "Accident and sickness carrier" means an entity licensed to offer accident and sickness insurance in this state, or subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services or any insurer that provides policies of supplemental, disability income, medicare supplement or long-term care insurance.

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

(3) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness or disease.

(4) "Policy form" means any policy, contract, certificate, rider, endorsement, evidence of coverage of any amendments thereto that are required by law to be filed with the commissioner for approval prior to their sale or issuance for sale in this state.

(5) "Supplemental documents" means any documents required to be filed in support of policy forms that may or may not be subject to approval.

(6) "Type of 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, 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.

~~(j)~~ *(k)* This section shall apply to any individual or group policy form issued by an accident and health carrier required to be filed with the commissioner for review or approval.

~~(k)~~ *(l)* Violations of subsection (d) shall be treated as violations of the unfair trade practices act and subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411 and amendments thereto.

~~(l)~~ *(m)* Hearings under this section shall be conducted in accordance with the provisions of the Kansas administrative procedure act.

Sec. 2. K.S.A. 40-2257 is hereby amended to read as follows: 40-2257. (a) Except as provided in this section, an accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits shall renew or continue in force such coverage at the option of the individual.

(b) An accident and sickness insurer may nonrenew or discontinue an individual policy providing hospital, medical or surgical expense benefits based only on one or more of the following:

(1) If the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the accident and sickness insurer has not received timely premium payments;

(2) if the individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) if the accident and sickness insurer is ceasing to offer individual policies providing hospital, medical or surgical expense benefits in accordance with subsection (c);

(4) in the case of accident and sickness insurer which offers individual policies providing hospital, medical or surgical expense benefits through enrollment area, if the individual no longer resides, lives or works in the medical service enrollment area (or in an area for which the accident and sickness insurer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(5) if the case of a policy providing hospital, medical or surgical ex-

pense benefits that is made available to individuals only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

(c) If the accident and sickness insurer decides to discontinue offering a particular individual policy providing hospital, medical or surgical expense benefits such policy may only be discontinue if:

(1) The accident and sickness insurer provides notice to each covered individual who is provided such policy providing hospital, medical or surgical expense benefits at least 90 days prior to the date of the discontinuation of such coverage;

(2) the accident and sickness insurer offers to each covered individual who is provided such policy providing hospital, medical or surgical expense benefits the option to purchase any other individual policy providing hospital, medical or surgical expense benefits which is being sold by the accident and sickness insurer; and

(3) in exercising the option to discontinue coverage and in offering the option of coverage under subsection (b), the accident and sickness insurer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for coverage under the policy.

(d) Subject to subsection (c), if the accident and sickness insurer elects to discontinue offering any individual policies providing hospital, medical or surgical expense benefits in this state, such insurance coverage may be discontinued only if:

(1) The accident and sickness insurer provides notice to the commissioner and to each individual policyholder of such discontinuation at least 180 days prior to the date of the expiration of such coverage; and

(2) the accident and sickness insurer is prohibited from the issuance of any individual policies providing hospital, medical or surgical expense benefits in the state during a ~~five-year~~ *one-year* period beginning on the date of the discontinuation of the last individual policy providing hospital, medical or surgical expense benefits which is not renewed.

(e) An accident and sickness insurer may modify the terms and conditions of the individual policy providing hospital, medical or surgical expense benefits so long as such modification is consistent with other provisions of the insurance code and is effective on a uniform basis among all individuals who are covered by such policy.

(f) In applying this section in the case of individual policies providing hospital, medical or surgical expense benefits that are made available by accident and sickness insurer to individuals only through one or more associations, a reference to an "individual" is deemed to include a ref-

erence to such an association of which the individual is a member.

(g) As used in this section, "health status-related factor" means: (1) A physical or mental illness medical condition; (2) claims experience; (3) receipt of health care; (4) medical history; (5) genetic information; (6) evidence of insurability including conditions arising out of acts of domestic violence; and (7) disability.

(h) As used in this section, "policies providing hospital, medical or surgical expense benefits" does not include short term, limited duration policies of insurance.

(i) The commissioner is hereby authorized to adopt such rules and regulations as may be necessary to carry out the provisions of this section.

Sec. 3. K.S.A. 40-2257 and K.S.A. 2008 Supp. 40-2215 are hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.