Approved: #?%?(¢
Date

MINUTES OF THE Senate Committee on Financial Institutions and Insurance.

The meeting was called to order by Chairperson Dick Bond at 9:00 a.m. on February 23, 1996 in Room 529-S of the Capitol.

All members were present.

Committee staff present: Dr. William Wolff, Legislative Research Department
Fred Carman, Revisor of Statutes
June Kossover, Committee Secretary

Conferees appearing before the committee: Tom Wilder, Kansas Insurance Department

Others attending: See attached list

Senator Petty made a motion to approve the minutes of the meeting of February 22 as submitted. Senator Steffes seconded the motion; the motion carried.

The committee convened today to receive the subcommittee report on **SB 477**, amending the health maintenance organization statutes. The subcommittee was chaired by Senator Praeger and consisted of Senator Petty and Senator Clark. Senator Praeger presented the balloon on **SB 477** prepared by the Revisor and stated that the subcommittee agreed with everything contained in the balloon except Section 14. (Attachment #1)

Tom Wilder, Kansas Insurance Department, explained the changes contained in the balloon. The Insurance Department finds the language on page 10 confusing; however, since this section was taken from NAIC model language, the revision will be acceptable to the Insurance Department. The language in Section 14 on page 17 is acceptable to the Insurance Department, but Mr. Wilder advised the committee that they may request further clarifying language when the bill is heard in the House. Mr. Wilder stated that although the Insurance Department is not in full agreement with all the proposed amendments, they are willing to accept the subcommittee recommendations.

Senator Praeger presented substitute language for Section 14, which the subcommittee recommended be adopted. (Attachment #2) Senator Praeger also requested that lines 39 and 40 on page 12 be stricken as this would seem to give the Insurance Department the authority to set policy. Senator Petty explained that the subcommittee questioned the legality of allowing the Insurance Department to set policy by rules and regulations.

Senator Praeger advised that the subcommittee did not have time to study the current holding company law and the NAIC language in new Section 15; therefore, she suggested leaving it as the Commissioner recommended with the expectation that this issue will be further examined as the bill progresses through the legislative process.

Mr. Carman pointed out that the word "full" should be stricken on page 5, line 34.

Senator Praeger made a motion to adopt the balloon amendments with the additional amendments listed above. Senator Petty seconded the motion. The motion carried.

Senator Praeger moved to pass **SB 477** favorably as amended. Senator Petty seconded the motion. The motion carried. Senator Praeger will carry this bill in the Senate.

The committee adjourned at 9:27 a.m.

SENATE FINANCIAL INSTITUTIONS & INSURANCE COMMITTEE GUEST LIST

DATE: 2/23/96

NAME	REPRESENTING
John Federico	Pete McGill + Assoc
Todd Lutz	Heartland Health
Jerry Slaughter	Ks. Medical Society
[illegible]	HIAD
[illegible]	SECURITY BENEFIT
Melissa Wangemann	Hein Elert & Weir
Tom Wilch	Kansas Insurance Dept
Kelly Kultala	KTLA
STEVE KEARNEY	CIGNA

Session of 1996

SENATE BILL No. 477

By Committee on Financial Institutions and Insurance

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AN ACT concerning insurance; health maintenance organizations; amending K.S.A. 40-204, 40-205, 40-205a, 40-239, 40-240, 40-3202, 40-3203, 40-3204, 40-3209, 40-3225, 40-3227 and 40-3302 and repealing the existing sections.

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

Section 1. K.S.A. 40-204 is hereby amended to read as follows: 40-204. It shall be unlawful for any insurance company *or health maintenance organization*, its agents or representatives, to offer the stock of such company for sale unless it shall have first obtained from the commissioner of insurance a permit authorizing and providing the terms of such sale. Any share of stock issued by an insurance company *or health maintenance organization* without a permit of the commissioner authorizing the same in effect at the time of issue, shall be void. Any share of stock issued under a permit of the commissioner shall be void unless its provisions conform to the provisions, if any, required by the permit.

Sec. 2. K.S.A. 40-205 is hereby amended to read as follows: 40-205. Each insurance company *or health maintenance organization* applicant for a permit to offer its stock for sale shall file with the commissioner an application therefor, verified by its president and secretary. The application shall set forth:

(a) The name of the company and the address of its principal office.

(b) The names and addresses of its officers.

(c) An itemized account of its financial condition, including the amount and character of its assets and liabilities.

(d) A detailed statement of the plan by which it proposes to offer its stock for sale and if the company has written no business in this state within the three years last preceding the date of the application, a detailed statement of any plan upon which it proposes to transact business in this state.

(e) A description of the stock it proposes to issue.

(f) Copies of any contracts, agreements or documents of any nature which have been made or are proposed to be made by the company or by those persons managing it or owning more than 10% of its stock which concern the stock to be offered

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Attachment #1

(d) (1) Agents licensed pursuant to subsection (b) shall advise the commissioner of any officers, directors, partners or employees who are licensed as individual insurance agents and are not disclosed at the time application is made for a license within 30 working days of their affiliation with the licensee. Failure to provide the commissioner with such information shall subject the licensee to a monetary penalty of $10 per day for each working day the required information is late subject to a maximum of $50 per person per licensing year.

(2) Officers, directors, partners or employees disclosed at the time of the original application or reported thereafter whose affiliation with the licensee is terminated shall be reported to the commissioner within 30 days of the effective date of termination. Failure to report such termination shall subject the licensee to the penalty prescribed in paragraph (1) of this subsection.

Sec. 6. K.S.A. 40-3202 is hereby amended to read as follows: 40-3202. As used in this act:

~~(a)~~ *"Administrative health service contract" means an agreement between a health maintenance organization and a health service intermediary or between health service intermediaries in which:*

(1) The intermediary accepts payments, including payments on a capitated, fixed per capita, fixed aggregate sum or percentage of premium basis, from the health maintenance organization for one or more health care services to be rendered by providers to enrollees of a health maintenance organization, where the intermediary assumes financial risk for payments to providers; and

(2) the intermediary contracts with providers to render one or more health care services to enrollees of a health maintenance organization

(a) ~~(a) (b)~~ "Commissioner" means the commissioner of insurance of the state of Kansas.

(b) ~~(b) (c)~~ "Basic health care services" means but is not limited to usual physician, hospitalization, laboratory, x-ray, emergency and preventive services and out-of-area coverage.

(c) ~~(d)~~ *"Capitated basis" means a fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. For purposes of this definition, capitated basis includes the cost associated with operating staff model facilities.*

(d) ~~(e)~~ *"Certificate of coverage" means a statement of the essential features and services of the health maintenance organization coverage which is given to the subscriber by the health maintenance organization or by the group contract holder.*

(e) ~~(f)~~ *"Copayment" means an amount an enrollee must pay in order to*

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receive a specific service which is not fully prepaid.

(f) ~~[(g)]~~ *"Deductible" means an amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.*

(g) ~~(e)~~ ~~[(h)]~~ "Director" means the secretary of health and environment.

~~(d)~~ *(i)* "Enrollee" means a person who has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization for health care services.

(j) "Grievance" means a written complaint submitted in accordance with the health maintenance organization's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the health maintenance organization relative to the enrollee.

(k) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents.

(l) "Group contract holder" means the person to which a group contract has been issued.

~~(e)~~ *(m)* "Health care services" means basic health care services and other services, medical equipment and supplies which may include, but are not limited to, medical, surgical and dental care; psychological, obstetrical, osteopathic, optometric, optic, podiatric, nursing, physical therapy services, chiropractic services and pharmaceutical services, health education, preventive medical, rehabilitative and home health services; inpatient and outpatient hospital services, extended care, nursing home care, convalescent institutional care, laboratory and ambulance services, appliances, drugs, medicines and supplies; and any other care, service or treatment for the prevention, control or elimination of disease, the correction of defects or the maintenance of the physical or mental well-being of human beings.

~~(f)~~ *(n)* "Health maintenance organization" means an organization which:

(1) Provides or otherwise makes available to enrollees health care services, including at a minimum those basic health care services which are determined by the commissioner to be generally available on an insured or prepaid basis in the geographic area served;

(2) is compensated, except for reasonable copayments, for the provision of basic health care services to enrollees solely on a predetermined periodic rate basis;

(3) provides physician services directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians or under arrangements as an independent contractor with a physician or any group of physicians;

(h) "Disability" means an injury or illness that results in a substantial physical or mental limitation in one or more major life activities such as working or independent activities of daily living that a person was able to do prior to the injury or illness.

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(4) is responsible for the availability, accessibility and quality of the health care services provided or made available.

~~(o)~~ *"Health service intermediary" or "intermediary" means a physician, hospital, physician-hospital organization, independent provider organization, independent provider network or other entity or person that arranges for one or more health care services to be rendered by providers to enrollees of a health maintenance organization. The term does not include a health maintenance organization.*

(o) ~~(p)~~ *"Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.*

(p) ~~(q)~~ *"Individual practice association" means a partnership, corporation, association or other legal entity which delivers or arranges for the delivery of basic health care services and which has entered into a services arrangement with persons who are licensed to practice medicine, ~~osteopathy~~, dentistry, chiropractic, pharmacy, podiatry, optometry or any other health profession and a majority of whom are licensed to practice medicine ~~or osteopathy~~. Such an arrangement shall provide:*

and surgery

(1) That such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(2) to the extent feasible for the sharing by such persons of medical and other records, equipment, and professional, technical and administrative staff.

(q) ~~(r)~~ *"Medical group" or "staff model" means a partnership, association or other group:*

(1) Which is composed of health professionals licensed to practice medicine ~~or osteopathy~~ and of such other licensed health professionals, including but not limited to dentists, chiropractors, pharmacists, optometrists and podiatrists as are necessary for the provision of health services for which the group is responsible;

(2) a majority of the members of which are licensed to practice medicine ~~or osteopathy~~; and

(3) the members of which: (A) As their principal professional activity over 50% individually and as a group responsibility are engaged in the coordinated practice of their profession for a health maintenance organization; (B) pool their income and distribute it among themselves according to a prearranged salary or drawing account or other plan, or are salaried employees of the health maintenance organization; (C) share medical and other records and substantial portions of major equipment and of professional, technical and administrative staff; and (D) establish an arrangement whereby the enrollee's enrollment status is not known to the member of the group who provides health services to the enrollee.

(r) "Net worth" means the excess of assets over liabilities as determined by the commissioner from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.

~~(s)~~ *(s)* "Person" means any natural or artificial person including but

not limited to individuals, partnerships, associations, trusts or corporations.

(u) ~~(h)~~ [t] "Provider" means any physician, hospital or other person which is licensed or otherwise authorized in this state to furnish health care services.

(v) ~~(i)~~ [u] "Uncovered expenditures" means the costs of health care services that are covered by a health maintenance organization for which an enrollee would also be liable in the event of the organization's insolvency as determined by the commissioner from the latest annual statement filed pursuant to K.S.A. 40-3220 and amendments thereto.

~~(j)~~ (w) "Net worth" means the excess of assets over liabilities as determined by the commissioner ~~from the latest annual report filed pursuant to K.S.A. 40-3220 and amendments thereto.~~

Sec. 7. K.S.A. 40-3203 is hereby amended to read as follows: 40-3203. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in subsection ~~(f)~~ (n) of K.S.A. 40-3202 and amendments thereto without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents.

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses ~~and~~, official capacity with the organization ~~of~~ *and biographical information for* all *of* the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

(4) *a copy of any contract or agreement made or to be made between the health maintenance organization and any* ~~health services intermediary or any other~~ [class] *of providers and a copy of any contract made or agreement made or to be made between third party administrators, marketing consultants or persons listed in subsection (3) and the health maintenance organization;*

~~(l)~~ (5) a statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation

(t) "Physician" means a person licensed to practice medicine and surgery under the healing arts act.

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of the facilities at which health care services will be regularly available to enrollees in the case of staff and group practices, the type and specialty of health care personnel and the number of personnel in each specialty category engaged to provide health care services in the case of staff and group practices, and a records system providing documentation of utilization rates for enrollees. In cases other than staff and group practices, the organization shall provide a list of names, addresses and telephone numbers of providers by specialty;

~~(5)~~ *(6)* copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

~~(6)~~ *(7)* the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization;

(C) financial projections using an accrual accounting system with generally accepted accounting principles for a minimum of three years from the anticipated date of certification and on a monthly basis from the date of certification through one year. If the health maintenance organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter. Financial projections shall include:

(i) Monthly statements of revenue and expense for the first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) a quarterly balance sheet; and

(iv) statement and justification of assumptions;

~~(7)~~ *(8)* a description of the procedure to be utilized by a health maintenance organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of policy and operation of the health maintenance organization;

(B) monitoring of the quality of care provided by such organization including, as a minimum, peer review; and

(C) resolving complaints and grievances initiated by enrollees;

~~(8)~~ *(9)* a written irrevocable consent duly executed by such applicant, if the applicant is a nonresident, appointing the commissioner as the person upon whom lawful process in any legal action against such organization on any cause of action arising in this state may be served and that such service of process shall be valid and binding in the same extent as if personal service had been had and obtained upon said nonresident in this state;

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~~(9)~~ *(10)* a plan, in the case of group or staff practices, that will provide for maintaining a medical records system which is adequate to provide an accurate documentation of utilization by every enrollee, such system to identify clearly, at a minimum, each patient by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy, and in all other cases, evidence that contracts with providers require that similar medical records systems be in place;

~~(10)~~ *(11)* evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care; and

~~(11)~~ *(12)* such other information as may be required by the commissioner to make the determinations required by K.S.A. 40-3204 and amendments thereto.

Sec. 8. K.S.A. 40-3204 is hereby amended to read as follows: 40-3204. *(a)* The commissioner shall ~~issue a certificate of authority to~~ *notify* any person filing an application *for a certificate of authority* within ~~sixty~~ ~~(60)~~ *60* days of such filing ~~unless he notifies the applicant within such time that~~ *if* such application is not complete or sufficient and the reasons therefor, or that payment of the fees required by K.S.A. 40-3213 *and amendments thereto* has not been made or that ~~he~~ *the commissioner* is not satisfied with the sufficiency of the information supplied pursuant to the provisions of K.S.A. 40-3203 *and amendments thereto* or that the organization has failed to demonstrate its ability to assure that health care services will be provided.

(b) The commissioner shall, within 60 days after the receipt of a completed application and any prescribed fees, issue a certificate of authority to any person filing such application if the commissioner finds that:

(1) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(2) any deficiencies identified by the commissioner in the application have been corrected;

(3) the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise except to the extent of reasonable requirements for copayments and/or deductibles; and

(4) the health maintenance organization is in compliance with K.S.A. 40-3227 and amendments thereto.

Sec. 9. K.S.A. 40-3209 is hereby amended to read as follows: 40-3209. (a) All forms of *group and individual certificates of coverage and* contracts issued by the organization to enrollees or other marketing documents purporting to describe the organization's health care services shall contain as a minimum:

[Not agreed to yet]

(c) The commissioner may promulgate rules and regulations the commissioner deems necessary to the proper administration of this act to require a health maintenance organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (b) to the commissioner prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to commissioner. Any modification or amendment for which the approval of the commissioner is required shall be deemed approved unless disapproved within 30 days, except the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.

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(1) A complete description of the health care services and other benefits to which the enrollee is entitled;

(2) the locations of all facilities, the hours of operation and the services which are provided in each facility in the case of ~~*independent*~~ *practice associations or medical* staff and group practices, and, in all other cases, a list of providers by specialty with a list of addresses and telephone numbers; individual

(3) the financial responsibilities of the enrollee and the amount of any deductible, copayment or coinsurance required;

(4) all exclusions and limitations on services or any other benefits to be provided including any deductible or copayment feature and all restrictions relating to pre-existing conditions;

(5) all criteria by which an enrollee may be disenrolled or denied reenrollment;

(6) service priorities in case of epidemic, or other emergency conditions affecting demand for medical services;

(7) a provision that an enrollee or a covered dependent of an enrollee whose coverage under a health maintenance organization group contract has been terminated for any reason but who remains in the service area and who has been continuously covered by the health maintenance organization for at least three months shall be entitled to obtain a converted contract or have such coverage continued under the group contract for a period of six months following which such enrollee or dependent shall be entitled to obtain a converted contract in accordance with the provisions of this section. The converted contract shall provide coverage at least equal to the conversion coverage options generally available from insurers or mutual nonprofit hospital and medical service corporations in the service area at the applicable premium cost. The group enrollee or enrollees shall be solely responsible for paying the premiums for the alternative coverage. The frequency of premium payment shall be the frequency customarily required by the health maintenance organization, mutual nonprofit hospital and medical service corporation or insurer for the policy form and plan selected, except that the insurer, mutual nonprofit hospital and medical service corporation or health maintenance organization shall require premium payments at least quarterly. The coverage shall be available to all enrollees of any group without medical underwriting. The requirement imposed by this subsection shall not apply to a contract which provides benefits for specific diseases or for accidental injuries only, nor shall it apply to any employee or member or such employee's or member's covered dependents when:

(A) Such person was terminated for cause as permitted by the group contract approved by the commissioner;

(B) any discontinued group coverage was replaced by similar group

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coverage within 31 days; or

(C) the employee or member is or could be covered by any other insured or noninsured arrangement which provides expense incurred hospital, surgical or medical coverage and benefits for individuals in a group under which the person was not covered prior to such termination. Written application for the converted contract shall be made and the first premium paid not later than 31 days after termination of the group coverage or receipt of notice of conversion rights from the health maintenance organization, whichever is later, and shall become effective the day following the termination of coverage under the group contract. The health maintenance organization shall give the employee or member and such employee's or member's covered dependents reasonable notice of the right to convert at least once within 30 days of termination of coverage under the group contract. The group contract and certificates may include provisions necessary to identify or obtain identification of persons and notification of events that would activate the notice requirements and conversion rights created by this section but such requirements and rights shall not be invalidated by failure of persons other than the employee or member entitled to conversion to comply with any such provisions. In addition, the converted contract shall be subject to the provisions contained in paragraphs (2), (4), (5), (6), (7), (8), (9), (13), (14), (15), (16), (18), (19) and (20) of subsection (D) of K.S.A. 40-2209, and amendments thereto; ~~and~~

(8) (A) group contracts shall contain a provision extending payment of such benefits until discharged or for a period not less than 31 days following the expiration date of the contract, whichever is earlier, for covered enrollees and dependents confined in a hospital on the date of termination; ~~and~~

(B) a provision that coverage under any subsequent replacement contract that is intended to afford continuous coverage will commence immediately following expiration of any prior contract with respect to covered services not provided pursuant to subparagraph (8)(A) ~~of this subsection.~~;

(9) an individual contract shall provide for a 10-day period for the enrollee to examine and return the contract and have the premium refunded, but if services were received by the enrollee during the 10-day period, and the enrollee returns the contract to receive a refund of the premium paid, the enrollee must pay for such services; and

(10) such other information as the commissioner may require by rules and regulations.

(b) No health maintenance organization authorized under this act shall contract with any provider under provisions which require enrollees to guarantee payment, other than copayments and deductibles, to such

provider in the event of nonpayment by the health maintenance organization for any services which have been performed under contracts between such enrollees and the health maintenance organization. Further, any contract between a health maintenance organization and a provider shall provide that if the health maintenance organization fails to pay for covered health care services as set forth in the contract between the health maintenance organization and its enrollee, the enrollee or covered dependents shall not be liable to any provider for any amounts owed by the health maintenance organization. If there is no written contract between the health maintenance organization and the provider or if the written contract fails to include the above provision, the enrollee and dependents are not liable to any provider for any amounts owed by the health maintenance organization.

(c) No *group or individual certificate of coverage or* contract form or amendment to an approved *certificate of coverage or* contract form shall be issued unless it is filed with the commissioner. Such contract form or amendment shall become effective within 30 days of such filing unless the commissioner finds that such contract form or amendment does not comply with the requirements of this section.

(d) Every contract shall include a clear and understandable description of the health maintenance organization's method for resolving enrollee grievances.

(e) The provisions of subsections (A), (B) and (C) of K.S.A. 40-2209 and 40-2215 and amendments thereto shall apply to all contracts issued under this section, and the provisions of such sections shall apply to health maintenance organizations.

Sec. 10. K.S.A. 40-3225 is hereby amended to read as follows: 40-3225. *(a)* Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the health maintenance organization.

(b) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on such employees and officers, directors and partners in the amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

Sec. 11. K.S.A. 40-3227 is hereby amended to read as follows: 40-3227. (a) Unless otherwise provided below, each health maintenance organization doing business in this state shall deposit with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities or any combination of these

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or other measures, *for the benefit of all of the enrollees of the health maintenance organization*, that are acceptable ~~in the amount set forth in this section~~ ~~for the payment of uncovered expenditures.~~

~~(b) The amount for an organization that is beginning operation shall be the greater of: (1) Five percent of its estimated expenditures for health care services for its first year of operation; or~~

~~(2) twice its estimated average monthly uncovered expenditures for its first year of operation; or~~

~~(3) $25,000.~~

~~At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the organization or trustee, cash, securities or any combination of these or other measures acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.~~

~~(c) Unless not applicable, an organization that is in operation on the effective date of this act shall make a deposit equal to the larger of: (1) One percent of the preceding 12 months' uncovered expenditures; or~~

~~(2) until April 1, 1989, $10,000. On and after April 1, 1989, organizations making deposits under this paragraph shall increase the amount of such deposit by an amount of not less than $1,500 per year until the deposit totals $25,000.~~

~~In the second year, if applicable, the amount of the additional deposit shall be equal to 2% of its estimated annual uncovered expenditures. In the third year, if applicable, the additional deposit shall be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth year and subsequent years, if applicable, the additional deposit shall be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate, after the first year of operation, shall reasonably reflect the prior year's operating experience and delivery arrangements.~~

~~(d)~~ *(b)* The commissioner may waive any of the deposit requirements set forth in ~~subsections (b) and (c)~~ *subsection (a)* whenever satisfied that: (1) The organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year; or (2) the organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or (3) the assets of the organization or its contracts with insurers, hospital or medical service corporations, governments or other organizations are reasonably sufficient to assure the performance of its obligations.

~~(e)~~ *(c)* When an organization has achieved a net worth not including land, buildings and equipment of at least $1,000,000 or has achieved a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply.

in the amount of $150,000 for a medical group or staff model health maintenance organization or $300,000 for an individual practice association

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(d) If the organization has a guaranteeing organization which has been in operation for at least five years and has a net worth not including land, buildings and equipment of at least $1,000,000 or which has been in operation for at least 10 years and has a net worth including land, buildings and equipment of at least $5,000,000, the annual deposit requirement shall not apply. If the guaranteeing organization is sponsoring more than one organization, the net worth requirement shall be increased by a multiple equal to the number of such organizations. This requirement to maintain a deposit in excess of the deposit required of an accident and health insurer shall not apply during any time that the guaranteeing organization maintains for each organization it sponsors a net worth at least equal to the capital and surplus requirements set forth in article 11 of chapter 40 of the Kansas Statutes Annotated for an accident and health insurer.

(e) The deposit requirements imposed by this act shall not apply to health maintenance organizations not organized under the laws of this state to the extent an amount equal to or exceeding that required by this act has been deposited with the commissioner or an organization or trustee acceptable to the department of insurance of its state of domicile for the benefit of Kansas enrollees.

(f) All income from deposits shall belong to the depositing organization and shall be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

~~(g) In any year in which an annual deposit is not required of an organization, at the organization's request the commissioner shall reduce the required, previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the organization not to make the annual deposit. If the amount of net worth no longer supports a reduction of its required deposit, the organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, provided that its total deposit shall not exceed the maximum required under this section.~~

~~*(g) All health maintenance organizations doing business in this state shall maintain insurance from an insurance company in an amount and form as may be required by the commissioner for the satisfaction of any liabilities of the health maintenance organization or the costs of liquidation in the event of an insolvency.*~~

(g) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(2) provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(3) insolvency reserves;

(4) acceptable letters of credit;

(5) any other arrangements to assure that benefits are continued as specified in this subsection (g).

New Sec. 12. A health maintenance organization shall provide in its certificate of coverage the procedures for resolving enrollee grievances.

At a minimum, the certificate of coverage shall include the following provisions:

(a) The definition of a grievance;

(b) how, where and to whom the enrollee should file such enrollee's grievance; and

(c) that upon receiving notification of a grievance related for payment of a bill for medical services, the health maintenance organization shall:

(1) Acknowledge receipt of the grievance in writing within 10 working days unless it is resolved within that period of time;

(2) conduct a complete investigation of the grievance within 20 working days after receipt of a grievance, unless the investigation cannot be completed within this period of time. If the investigation cannot be completed within 20 working days after receipt of a grievance, the enrollee shall be notified in writing within 30 working days time, and every 30 working days after that, until the investigation is completed. The notice shall state the reasons for which additional time is needed for the investigation;

(3) have within five working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation decide upon the appropriate resolution of the grievance and notify the enrollee in writing of the decision of the health maintenance organization regarding the grievance and of any right to appeal. The notice shall explain the resolution of the grievance and any right to appeal. The notice shall explain the resolution of the grievance in terms which are clear and specific; and

(4) notify, if the health maintenance organization has established a grievance advisory panel, the enrollee of the enrollee's right to request the grievance advisory panel to review the decision of the health maintenance organization. This notice shall indicate that the grievance advisory panel is not obligated to conduct the review. This provision shall also state how, where and when the enrollee should make such enrollee's request for this review.

New Sec. 13. (a) A health maintenance organization that requires prior authorization before making payment for the treatment of medical emergency conditions, as defined by the health maintenance organization, shall provide enrollees with a toll-free telephone number answered 24 hours per day, seven days a week. At least one person with medical training who is authorized to determine whether an emergency condition exists shall be available 24 hours per day, seven days a week to make these determinations.

(b) A health maintenance organization shall not base its denial of payment for emergency medical services solely on the failure of the enrollee to receive authorization prior to receiving the emergency medical

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service. The enrollee must notify the health maintenance organization of receipt of medical services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event of a plan termination or termination of the participation of a provider with the plan. ~~Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.~~

~~New Sec. 15. A health maintenance organization may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner, is accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the health maintenance organization is financially sound, and the contract contains provisions which:~~

[Not yet agreed to]

The plan shall include provisions for the continuation of care to enrollees by a provider who is terminated from a network in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence and where the enrollee has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy. The provisions for the continuation of care shall include guarantees that the enrollee will not be liable to the provider for any amounts owed for medical care other than any deductibles or co-payment amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization.

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(1) Require the health service intermediary to provide the health maintenance organization and the commissioner, with a regular written financial reports, at least quarterly, that state the assets of the health service intermediary and identify in the aggregate all payments made or owed to its providers in sufficient detail for the health maintenance organization and the commissioner to determine if the payments are being made in a timely manner and which identify in the aggregate the reasonably estimated incurred but not reported health care costs;

(2) require the health maintenance organization to monitor the financial reports required by the health service intermediary under this subsection;

(3) permit the health maintenance organization and the commissioner, both singularly and jointly, upon reasonable prior notice, to audit, inspect and copy the books, records and other evidence of the operations of the health service intermediary which are, in the discretion of the health maintenance organization or the commissioner, relevant to the obligations of the intermediary under the administrative health service contract for the purpose of determining the intermediary's compliance with all requirements legally mandated by statute, rules and regulations or the administrative health service contract subject to any confidentiality requirements imposed by state or federal law;

(4) any additional information which the commissioner may require by rules and regulations.

As used in this section, the term "financially sound" means that according to presently accepted actuarial standards of practice, consistently applied and fairly stated, that the respective considerations to the parties under the contract, including, but not limited to, reserves, the investment earnings on such considerations, the considerations anticipated to be received and retained by the parties under the contract, and related actuarial values, make adequate provision for the anticipated cash flows required by the contractual obligations and related expenses of the parties.

Sec. 16. K.S.A. 40-3302 is hereby amended to read as follows: 40-3302. As used in this act, unless the context otherwise requires:

(a) "Affiliate" of, or person "affiliated" with, a specific person, means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(b) "Commissioner of insurance" means the commissioner of insurance, the commissioner's deputies, or the insurance department, as appropriate.

(c) "Control" including the terms "controlling," "controlled by" and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and

policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other person. This presumption may be rebutted only for registration purposes pursuant to K.S.A. 40-3305 and amendments thereto by a showing made in the manner provided by subsection (i) of K.S.A. 40-3305 and amendments thereto, that control does not exist in fact. The commissioner of insurance may determine, after a hearing in accordance with the provisions of the Kansas administrative procedure act, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(d) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(e) "Insurer" means any corporation, company, association, society, fraternal benefit society, *health maintenance organization*, mutual nonprofit hospital service corporation, nonprofit medical service corporation, nonprofit dental service corporation, nonprofit optometric service corporation, reciprocal exchange, person or partnership writing contracts of insurance, indemnity or suretyship in this state upon any type of risk or loss except lodges, societies, persons or associations transacting business pursuant to the provisions of K.S.A. 40-202 and amendments thereto.

(f) "Person" means an individual, corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(g) "Securityholder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(h) "Subsidiary" of a specified person means an affiliate controlled by such person directly, or indirectly, through one or more intermediaries.

(i) "Voting security" means any security convertible into or evidencing a right to acquire a voting security.

16 Sec. 17. K.S.A. 40-204, 40-205, 40-205a, 40-239, 40-240, 40-3202, 40-3203, 40-3204, 40-3209, 40-3225, 40-3227 and 40-3302 are hereby repealed.

17 Sec. 18. This act shall take effect and be in force from and after its publication in the statute book.

[Not yet agreed to]

Sec. 15. No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of securities if no offer or agreement is involved, the person has filed with the commissioner information required by subsection (b) of K.S.A. 40-3304 and amendments thereto and the offer, request, invitation, agreement or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by subsection (d) of K.S.A. 40-3304 and amendments thereto.

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service. The enrollee must notify the health maintenance organization of receipt of medical services for emergency conditions within 24 hours or as soon after that as is reasonably possible. Nothing shall require the health maintenance organization to authorize payment for any services provided during that 24 hour period, regardless of medical necessity, if those services do not otherwise constitute benefits under the certificate of coverage approved by the commissioner.

(c) If the participating provider is responsible for seeking prior authorization from the health maintenance organization before receiving payment for the treatment of emergency medical conditions and the enrollee is eligible at the time when covered services are provided, then the enrollee will not be held financially responsible for payment for covered services if the prior authorization for emergency medical services has not been sought and received, other than for what the enrollee would otherwise be responsible, such as copayments and deductibles.

(d) All disputes between an enrollee and a health maintenance organization arising under the provisions of this section shall be resolved by means of the grievance procedures established by the health maintenance organization.

New Sec. 14. A health maintenance organization shall establish reasonable procedures for assuring a transition of enrollees to physicians or health care providers and for continuity of treatment, including providing immediate notice to the enrollee and making available to the enrollee a current listing of preferred providers, in the event ~~of a plan termination or termination of the participation of a provider with the plan. Each contract between a health maintenance organization and a physician or health care provider must provide that in the event of plan termination, or termination of the participation of a provider with the plan, such action shall not release the physician or health care provider from the generally recognized obligation to treat the enrollee and cooperate in arranging for appropriate referrals or release the obligation of the health maintenance organization to reimburse the enrollee at the same preferred provider rate for a period of up to 90 days if, at the time of plan or provider termination, the enrollee has special circumstances such as a disability, life threatening or complex illness or is in the third trimester of pregnancy and is receiving treatment in accordance with the dictates of medical prudence.~~

New Sec. 15. A health maintenance organization may not enter into an administrative health service contract with a health service intermediary unless the contract is in writing, is filed with the commissioner, is accompanied by an opinion by a qualified independent actuary which states that the entering of the contract by the health maintenance organization is financially sound, and the contract contains provisions which:

a provider's participation in the plan is terminated for any reason. If the plan authorizes the terminated provider to continue treating the enrollee, the plan shall have an obligation to pay the terminated provider at the previously contracted rate for such services and the enrollee will not be liable for any amounts owed for medical care other than any deductibles, co-insurance or co-payment amounts specified in the certificate of coverage or other contract between the enrollee and the health maintenance organization.

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Attachment #2