SESSION OF 2006

SUPPLEMENTAL NOTE ON SENATE SUBSTITUTE FOR HOUSE BILL NO. 2366

As Amended by Senate Committee of the Whole

Brief*

Senate Sub. for HB 2366, as amended, would amend certain rate filing requirements for casualty insurance companies and enact new law for a risk adjustment method. The bill also would amend the Kansas Automobile Injury Reparations Act to clarify the penalties in current law for individuals who are convicted of failure to provide proof of financial security and amend the requirements for the suspension or revocation of a driver's license. The bill also would enact new law to provide insureds with certain appeals rights for adverse health care decisions made through a utilization review process.

Rate and Form Filling Requirements

The bill would amend certain rate filing requirements for casualty insurance companies and enact new law for a risk adjustment method. The bill would remove the current policy form filing requirement that certain contracts of commercial insurance or indemnity not be issued or delivered until the form has been filed with the Insurance Commissioner or if the Commissioner gives written notice within 30 days of the filing and demonstrates that the form does not comply with requirements of state law. Exceptions to the new filing requirements, which allow for file and use, include contracts for large risks, basic professional liability coverage for health care providers, and workers compensation. These filings would continue to be subject to prior approval by the Commissioner. The amended filing requirements include:

- Contracts of insurance or indemnity issued or delivered in Kansas would be effective on filing or any subsequent date selected by the insurer, unless the Commissioner disapproves such contract within 30 days after the filing because the rates are determined to be inadequate, excessive, unfairly discriminatory

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

or otherwise fail to meet the requirements of this act.

- Contracts that pertain to large risks, as defined in KSA 40-955(I), noncommercial personal lines, basic professional liability coverages required by KSA 40-3401 *et seq*., and workers compensation would be exempt from this filing requirement. No form filing for either the basic professional liability coverage for health care providers or workers compensation is to be used in this state by any insurer until such form filing has been approved by the Commissioner.

- Each personal lines contract of insurance or indemnity issued or delivered in this state would be required to be on file for a period of 30 days before becoming effective unless the Commissioner disapproves such contract if the rates are determined to be inadequate, excessive, unfairly discriminatory or otherwise fail to meet the requirements of this act. Personal lines of insurance are defined in this provision as insurance for noncommercial automobile, homeowners, dwelling, fire and renters insurance policies as defined by the Commissioner by rules and regulations.

The bill also would create a hearing process for filings that have become effective but are found to not comply with this act. The Commissioner would be required to send written notice to every insurer and rating organization making such filing that a hearing concerning the filing will be held in ten or more days. After the hearing, the Commissioner is to issue an order that states the reasons why such filing failed to comply with the act; and the date, within a reasonable time after the date the order is issued, upon which such filing would no longer be effective. A copy of the order is to be sent to every insurer and rating organization that made the filing. No order issued pursuant to this provision is to affect any contract or policy made or issued under such filing prior to the date specified upon which the filing is to no longer be effective.

New law would be created by the bill to allow for a risk adjustment method that would permit insurers to:

- Increase or decrease premiums on a given risk basis without documentation up to 40 percent based on any factor, with the exceptions that the adjustment could not be based upon the race, creed, national origin, or religion of the insured and could not apply to insurance covering:

- Personal lines: risks of a personal nature, including insurance for homeowners, tenants, private passenger nonfleet automobiles, mobile homes and other property and casualty insurance for personal, family, or household needs;
- Farms and ranches, including crop insurance;
- Workers compensation; or
- The basic professional liability coverage required by KSA 40-3401 *et seq*.

The Commissioner, in accordance with the Rules and Regulations Filing Act, would be permitted to broaden the range of plus or minus 40 percent for any line or type of insurance subject to KSA 40-955, if the Commissioner finds that the utilization of this new law has produced a significant number of rate modifications at or near the upper limit and at the lower limit of the allowable range of modification; and modifiers at and near the upper limits of the allowable range appear to be predominantly correlated with individual risk factors that relate to expected losses and expenses.

The Commissioner, also in accordance with the Rules and Regulations Filing Act, would be permitted to reduce the range of plus or minus 40 percent for any line or type of insurance subject to KSA 40-955, if the Commissioner finds that modifiers at or near the upper or lower limits of the allowable range are not predominantly correlated with individual risk factors that relate to expected losses and expenses, but the reduction would not be permitted to reduce the range to less than plus or minus 25 percent.

Finally, the bill would allow any insurer aggrieved by the Commissioner's finding be allowed to appeal, pursuant to the Kansas Administrative Procedure Act. (Sections 1-4)

Kansas Automobile Injury Reparations Act Amendments

The bill also would amend the Kansas Automobile Injury Reparations Act to clarify the penalties in current law for individuals who are convicted of failure to provide proof of financial security, which is defined as the requirement to carry motor vehicle liability insurance coverage while operating a motor vehicle. Specifically, the bill would provide that upon:

- A first conviction of a violation, the person would be guilty of a Class B misdemeanor. The individual would be subject to a fine, as provided by current law, of not less than $300 but not more

than $1,000 or confinement in the county jail for a term not to exceed six months, or both fine and confinement; and

- A second or subsequent conviction of a violation within five years of a prior conviction, the person would be guilty of a Class A misdemeanor. The individual would be fined, as provided by current law, not less than $800 but not more than $2,500.

The bill would remove current law provisions for reinstatement of an individual's driver's license by providing satisfactory proof of financial security. Specifically, the bill would amend current law requirements to allow a license to remain suspended or revoked until the individual has:

- Filed satisfactory proof of financial security with the Director of Vehicles as required by subsection(d) of KSA 40-3118;

- Paid the reinstatement fee; and

- Been released from liability, is a party to an action to determine liability pursuant to which the court temporarily stays such suspension pending the final disposition of the action, has entered into an agreement for the payment of damages, or has been finally adjudicated not to be liable in respect to the accident and evidence of any such fact has been filed with the Director.

The bill also would provide that the reinstatement fee is to be $100, with an exception that if the registration of the motor vehicle owner is revoked within one year following a prior revocation of the owner's registration, the fee would be $300.

The bill also would include provisions that whenever an individual involved in an accident whose license has been suspended or revoked pursuant to this act and has entered into an agreement with any driver, or the driver's insurer, who has been damaged or whose vehicle has been damaged to pay for such damage and such person defaults on payments under the agreement, the driver or the driver's insurer is to notify the Director within 60 days of the default date. Upon the receipt of the default notice, the Director would be required to immediately suspend the person's license and registration. If the person is a nonresident, the Director is to immediately suspend the person's nonresident privilege to operate a motor vehicle in this state.

The person's driver's license, registration, and the nonresident's operating privilege would remain suspended and not renewed, and no license or registration would be issued in the name of this individual, including any person not previously licensed, unless and until:

- The Director receives notice that payments under the agreement between the drivers, and if applicable, the driver's insurer, have been resumed and the payments are no longer in default;

- Such person has filed satisfactory proof of financial responsibility; and

- The reinstatement fee has been paid.

Upon the due notice to the Director that these conditions have been met, the person would be permitted to obtain, from the Director, an order restoring the person's driver's license, registration and nonresident's operating privilege to operate a motor vehicle in Kansas. The restoration would be conditional upon the person's continued compliance with the agreement.

In the event the person fails to make any further payment under the agreement when such payment is due, the Director upon receipt of the default notice, is to immediately suspend the license, registration or nonresident's operating privilege of the person until all payments have been made under the agreement. (Section 5)

Internal Appeal and Review Process Rights—Health Insurance

The bill would enact new law to provide insureds with certain appeals rights for adverse health care decisions made through a utilization review process. Specifically, the bill would require every health insurance plan for which utilization review is performed to include a description of the plan's procedures for an insured to obtain internal review of an adverse decision. The description would be required to include all applicable time periods, contact information, rights of the insured, and available levels of appeal. If the health insurer uses a utilization review organization, its insured is to be notified of the name of the organization. The plan also would be required to provide an insured with written or electronic notification of any adverse decision and a description of the plan's review procedure, including the insured's right to external review as provided in KSA 40-22a14. In addition, the plan would be required to notify the insured of

the insured's right to waive the second appeal or internal review and proceed directly to the external review.

If the health insurance plan utilization review contains a provision for two levels of internal review of an adverse health care decision, the plan would be required to allow the insured to voluntary waive the insured's right to the second appeal or internal review.

The bill also would provide that if an insured elects to request the second appeal or internal review of a health care decision that is adverse to the insured, the insured would have the right to appear in person before the health insurance plan or utilization review organization's designated representatives at the second appeal or internal review meeting. If a majority of the designated representatives of the health plan or utilization review organization deciding the appeal or review cannot be present in person, by telephone, or by other electronic means, at least one is required to be a physician and be present in person, by telephone, or by other electronic means. Any physician or health care provider serving as a reviewer in the second appeal or internal review could not be held liable in damages to either the insured or the health insurance plan for any opinion the provider rendered as part of the appeal or review.

All second appeals or internal reviews would be required to provide that the insured has the right to:

- Receive, upon request, from the plan or utilization review organization, copies of all documents, records, and other information that are not confidential or privileged relative to benefits;

- Have a reasonable and adequate amount of time to present the insured's case to a designated representative or representatives of the plan or utilization review organization who will be deciding the second internal appeal or review;

- Submit written comments, questions, documents, records and other material relating to the request for benefits for the panel to consider when conducting the second internal appeal or review meeting both before and, if applicable, after the second internal appeal or review meeting;

- Prior to or during the second internal appeal or review meeting, ask questions relevant to the subject matter of the appeal or review of any representative of the plan or utilization review

organization serving on the internal appeal or review panel provided that such representative may respond verbally if the question is asked in person during an insured's appearance before the internal appeal or review panel or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

- Be assisted or represented at the second appeal or internal review meeting by an individual or individuals of the insured's choice; and

- Record the proceedings of the second appeal or internal review meeting at the expense of the insured.

The bill also would provide that the insured, or insured's authorized representative who wishes to appear in person before the second appeal or internal review panel consisting of the health insurance plans or utilization review organization's designated representative or representatives is to make the request to the health insurance plan or utilization review organization within five working days before the date of the scheduled meeting. The bill would create an exception for emergency medical conditions, allowing that in such case, the request must be made no less than 24 hours prior to the scheduled review meeting.

Finally, the plan or utilization review organization would be required to provide the insured a written decision that sets forth the relevant facts and conclusions supporting its decision within:

- 72 hours if the second internal appeal or review involves an emergency medical condition as defined in subsection (b) of KSA 40-22a13;

- Fifteen business days if the second internal appeal or review involves a pre-service claim; and

- 30 days if the second internal appeal or review involves a post-service claim. (Section 6)

Background

The bill was introduced by Representatives Carter, Brown, Huy, E. Johnson, Kelley, Kiegerl, Kilpatrick, Kinzer, Merrick, Jim Morrison,

and Pilcher-Cook. The bill, as introduced, was supported by Humana, the Kansas Chamber of Commerce, Lenexa Chamber of Commerce, and the Wichita Independent Business Association. A representative from America's Health Insurance Plans expressed support for the bill if the provision related to the approval of health plans by the Insurance Commissioner was reinstated. The Kansas Insurance Department was neutral on passage of the bill.

The bill, as introduced, was opposed by the Kansas Association of Insurance Agents and the Kansas Dental Association whose representatives expressed concern about the removal of the Insurance Department's ability to approve health insurance forms.

The House Committee on Insurance amendments reinstated the provisions of KSA 40-2215 allowing the Insurance Commissioner the ability to disapprove the insurance form based on factors relating to the premium charge or provisions that are unjust, misleading, deceptive or misrepresent the policy. The Committee amendments also provided that the group or individual plans comply with state or federal insurance law relating to required benefits for accident and sickness policies.

The House Committee of the Whole amendment inserted the provisions of existing law, KSA 40-2257, with modified language relating to the terms of accident and sickness policies. The amendment inserts the language from 2005 HB 2255.

The Senate Committee on Financial Institutions and Insurance recommended a substitute bill. The substitute incorporates the provisions of Sub. for SB 539 (as recommended by the Senate Committee), Sub. for SB 322 (as amended by the Senate Committee of the Whole), and House Substitute for SB 522. The provisions of SB 522 do not reflect the House Committee amendment to allow for written notification of the insured's ability to forego the second appeal or internal review level and utilize external review.

The Senate Committee of the Whole amendment removes the provisions of KSA 40-954 from the bill. One amendment had been proposed in the original substitute to KSA 40-954, for rate modification for individual risk to allow for modification in accordance with section 4 of that bill.

A fiscal note was not available for the substitute bill.