Session of 2011

HOUSE BILL No. 2208

By Committee on Insurance

2-8

AN ACT concerning insurance; relating to rate review for individual health insurance policies; relating to the individual market health insurance rate review act; amending K.S.A. 2010 Supp. 40-2215 and repealing the existing section.

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

New Section 1. (a) Any insurer desiring to change rates on any policy form, contract, or certificate shall submit electronically a rate filing request for approval with the commissioner. No rate or change to a rate shall be used unless approved by the commissioner, and unless policyholders have received notice as required in section 7, and amendments thereto.

(b) Within 30 days of the close of the 60-day public comment period required under section 3, and amendments thereto, the commissioner shall issue a written decision with findings on the considerations listed in section 5, and amendments thereto, and any other considerations taken into account, to approve, modify, or disapprove the proposed rates. If, however, a hearing on the proposed rate change is held under section 8, and amendments thereto, the commissioner may reasonably extend the time to issue a written decision with findings to approve, modify, or disapprove the proposed rate change to accommodate a hearing schedule.

(c) Upon issuing the decision, the commissioner shall post the commissioner's decision on the department's website and provide written notice to the insurer of the decision.

(d) Failure to submit all of the information required or requested by the commissioner under section 3, and amendments thereto, shall make the rate filing incomplete. Within 10 days of receiving a rate filing for a proposed rate change, the commissioner shall determine whether the filing is complete. If the commissioner determines that a filing is incomplete, the commissioner shall notify the insurer in writing that the filing is deficient and give the insurer an opportunity to provide the missing information.

(e) All applicants governed under article 17 of chapter 17 of the Kansas Statutes Annotated, and amendments thereto, shall provide a copy of the filing on all rates proposed for health insurance coverage offered in the individual market to the attorney general's office simultaneously with

the filing at the office of the commissioner.

(f) Approved rates shall be guaranteed by the insurer, as to the policyholders affected by the rates, for a period of not less than 12 months, or as an alternative to the insurer giving the guarantee, the approved rates may be applicable to all policyholders at one time if the insurer chooses to apply for that relief with respect to those policies no more frequently than once in any 12-month period.

New Sec. 2. (a) Upon receipt of a rate filing requesting a rate change, within three business days, the commissioner shall, post the rate filing including all information required under section 3, and amendments thereto, on its department website, along with the insurer's rate filing summary required under section 3, and amendments thereto .

(b) The commissioner shall prominently post links on the department's homepage to a webpage on which rate filings and summaries can be found. Links to rate filings and summaries shall be clearly labeled by name of the insurer, type of policy, and the filing date of the proposed rate change. If a commissioner uses a searchable database to publicly post rate filings, the commissioner shall post search instructions and plain-language explanatory material sufficient to make it easy to find a rate filing in the database.

New Sec. 3. (a) Every rate filing submitted under section 1, and amendments thereto, for a proposed rate change shall include sufficient information and data to allow the commissioner to consider the factors set forth in section 5, and amendments thereto, any factors established under federal regulations concerning "unreasonableness" of premiums, and any other factors required by the commissioner.

(b) (1) The information in the rate filing shall be presented with information clearly labeled under headings in a standard format to be determined by rules and regulations adopted by the commissioner. The commissioner shall adopt rules and regulations to establish the specific data and information required to be included in the rate filing necessary to allow the commissioner to consider the factors in section 5, and amendments thereto, any factors under federal or state law, and any other information that the commissioner determines should be submitted.

(2) The commissioner may adopt and require use of the disclosure form used for justification of premium increases under §1003(a)(2) of the patient protection and affordable care act (PPACA), except that the commissioner shall require additional disclosures in a standard format to the extent that the PPACA disclosure form does not include the information required to consider the factors in section 5, and amendments thereto, the information required under this section, and any additional information that the commissioner determines should be submitted.

(3) The regulations establishing the specific data and information

required in the filing shall ensure that each filing includes, but is not limited to:

(A) A rate filing summary which explains the filing in a manner that allows consumers to understand the rate change. The summary shall be in accordance with a form established by the commissioner. The information contained in this summary shall match the information provided elsewhere in the filing.

(B) An actuarial memorandum that:

(i) Describes the benefit plan for each product and a description of any changes to the benefit plan;

(ii) reports the following:

(a) The insurer's overall medical trend factor assumed, and also broken down by rate of price inflation and rate of utilization change;

(b) the insurer's claims history for at least five years;

(c) the insurer's claims history, for at least five years, by rate of price inflation and utilization, mix of services, and by category of type of medical reimbursement, including, but not limited to, hospital inpatient, hospital outpatient, physician services, prescription drugs and other ancillary services, laboratory, and radiology;

(d) the insurer's claims history for at least five years, by major geographic region of the state. For purposes of this provision "major geographic region" shall correspond to any areas defined under any geographic rating factors used, or as defined by the commissioner by rule and regulation; and

(e) any insurer requesting a rate change shall also provide information on aggregate cost increases for specific hospitals and for specific medical groups within a plan network, if requested by the commissioner.

(c) (1) The actuarial memorandum shall explain how the proposed rate change was calculated, including a description of all assumptions, factors, calculations and any other information pertinent to the proposed rate. The insurer shall clearly identify and quantify medical trend factors and all other factors used in developing the rates. The insurer shall show all tier factors used, if any, age bands and factors used, geographic factors used, and benefit-level factors used.

(2) The insurer shall provide detailed support for each assumption used to determine the proposed rate change. These assumptions shall each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration and time period. Any and all factors affecting the projection of future claims shall be presented and adequately supported.

(3) The actuarial memorandum shall include rate tables presented as determined by the commissioner.

(4) The actuarial memorandum shall include, for each plan subject to a proposed increase, the average increase, as well as the maximum increase to be charged for any policyholder and the minimum increase to be charged for any policyholder.

(5) The actuarial memorandum shall include a signature of and date that a qualified actuary reviewed the rate filing.

(d) The insurer shall explain any changes the insurer has made in its health care cost containment efforts and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan, including a description of any factors that relate to the commissioner's consideration of affordability under section 5, and amendments thereto.

(e) The insurer shall include information sufficient to show expenses relating to:

(1) Salaries, wages, bonuses or other compensation benefits;

(2) broker commissions;

(3) rent or occupancy expenses;

(4) marketing and advertising;

(5) federal and state lobbying expenses;

(6) all political contributions;

(7) all dues paid to trade groups that engage in lobbying or make political contributions;

(8) general offices expenses, including but not limited to sundries, supplies, telephone, printing and postage;

(9) third party administration expenses or fees or other group service expense or fees;

(10) legal fees and expenses and other professional or consulting fees;

(11) other taxes, licenses and fees;

(12) travel expenses; and

(13) charitable contributions.

When possible, the insurer should show how the expenses in this section were applied on a per member per month basis to the rates subject to the proposed rate change.

(f) The rate application shall be signed by the officers of the insurer who exercise the functions of a chief executive and chief financial officer. Each officer shall certify that the representations, data and information provided to the department to support the application are true and that the filing complies with state statutes, rules, product standards and filing requirements.

New Sec. 4. (a) An insurer shall send written notice of a proposed rate change to each policyholder affected by the change on or before the date the rate filing or application is submitted to the commissioner. The

notice shall:

(1) State in size 16-point font in bold the actual dollar amount of the proposed rate change and the specific percentage by which the current premium would be increased for the policyholder;

(2) describe in plain, understandable terms any changes in the plan design or any changes in benefits, and highlight this information by printing in 16-point font in bold;

(3) prominently include mailing and website addresses and telephone numbers for the insurer through which a person may request additional information;

(4) provide information about public programs, including but not limited to medicaid, high risk pools, and CHIP, which provides health insurance for children; and

(5) state that the proposed rate change is subject to approval by the department, and inform policyholders of the 60-day public comment period available under this section, and amendments thereto, and provide the website address of the department where the rate filing can be found.

(b) The commissioner shall make available an email alert system in which members of the public may sign up on the commissioner's website to receive notice of a proposed rate change for a selected insurer. The commissioner shall send such email alerts within three business days after receiving a rate filing proposing a rate change.

(c) Beginning on the date that the commissioner posts on the department website a proposed rate change pursuant to section 2, and amendments thereto, the commissioner shall open a 60-day public comment period on the rate change and rate filing. The commissioner shall allow members of the public to comment by mail and email, and the commissioner may create a website where members of the public can publicly post comments. The commissioner, in the commissioner's discretion, may convene meetings around the state for consumers to comment and ask questions. The commissioner shall prominently post on the department website information describing the public comment period that applies to proposed rate changes and informing members of the public how to submit a comment.

(d) If a rate filing is found to be incomplete under section 3, and amendments thereto, the commissioner shall start a new 60-day public comment period after the commissioner determines that the filing is complete and posts the insurer's complete filing on the department website.

Within 30 days of the close of the 60-day public comment period required under this section, the commissioner shall issue a written decision with findings on the considerations listed in section 5, and amendments thereto, and any other considerations taken into account, to

approve, modify, or disapprove the proposed rates. If, however, a hearing on the proposed rate change is held under section 8, and amendments thereto, the commissioner may reasonably extend the time to issue a written decision with findings to approve, modify or disapprove the proposed rate change to accommodate a hearing schedule. Upon issuing the decision, the commissioner shall post the commissioner's decision on the department's website and provide written notice to the insurer of the decision.

New Sec. 5. (a) When making any determination under this act, the commissioner shall act to guard the solvency of health insurers, protect the interests of consumers of health insurance and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate affordability of coverage and access.

(b) Rates shall be actuarially sound, reasonable, based on reasonable administrative expenses and not excessive, inadequate, or unfairly discriminatory. Rates may not be deceptive or constitute an unfair trade practice. An insurer shall have the burden to show by clear and convincing evidence that its rates comply with the terms of this subsection.

(c) The commissioner shall disapprove a proposed rate change if the proposed rates are not actuarially sound, nor unreasonable, excessive, inadequate, nor unfairly discriminatory, based on unreasonable administrative expenses, not in the public interest, or if the rate filing is incomplete. In making the determination, the commissioner shall consider and issue findings on the following factors:

(1) Reasonableness and soundness of actuarial assumptions, calculations, projections, and factors used by the insurer to arrive at the proposed rate change;

(2) the insurer's historical trends for medical claims. The commissioner may consider, for comparison, medical trends reported by other insurers in the state, or of medical trends for the state, a region, or the country as a whole. The commissioner shall also consider inflation indices, such as the consumer price index and the medical care component of the consumer price index;

(3) reasonableness of historical and projected administrative expenses;

(4) compliance with medical loss ratio standards in effect under federal or state law. The commissioner may review and consider the insurer's medical loss ratio disclosures submitted pursuant to the patient protection and affordable care act;

(5) whether the rate change applies to an open or closed block of business. If it applies to a closed block of business, whether the applicant

has pooled the experience of the closed block of business with all appropriate blocks of business that are not closed pursuant to section 6, and amendments thereto;

(6) whether the insurer has complied with all federal and state requirements for pooling risk and requirements for participation in risk adjustment programs in effect under federal and state law;

(7) the financial condition of the insurance company for at least the past five years, including but not limited to, profitability, surplus, reserves, investment income, reinsurance, dividends, and transfers of funds to affiliates or parent companies, or both;

(8) whether the proposed rate change and any contribution to surplus or profit margin included in the proposed rate change is reasonable in light of the entire company's surplus level and additional factors in the previous subsection;

(9) the financial performance for at least the past five years, or total years in existence if less, of the block of business subject to the proposed rate change, including but not limited, to past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block;

(10) the financial performance for at least the past five years of insurer's statewide individual market business, and the insurer's overall statewide business;

(11) any anticipated change in the number of enrollees if the proposed premium rate is approved;

(12) any change to covered benefits or health benefit plan design;

(13) whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future;

(14) the insurer's statement of purpose or mission in its corporate charter or mission statement;

(15) the hardship on members affected by the proposed rate change;

(16) public comments received under section 4, and amendments thereto, pertaining to the standards set forth in this section;

(17) affordability of the insurance product or products subject to the proposed rate change. To assess affordability, the commissioner shall consider efforts of the insurer to maintain close control over its administrative costs, and changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same product, including:

(A) Implementation of strategies by the insurer to enhance the affordability of its products, including whether the insurer offers products that address the underlying cost of health care by creating appropriate incentives for consumers, employers, providers and the insurer itself that

promote focus on primary care, prevention and wellness, active management procedures for the chronically ill population; use of appropriate cost-efficient settings and use of evidence-based quality care;

(B) whether the insurer employs provider payment strategies to enhance cost effective utilization of appropriate services;

(C) five-year rate change history for the population affected by the proposed rate change;

(D) constraints on affordability efforts including:

(i) State and federal requirements;

(ii) costs of medical services over which plans have limited control;

(iii) health plan solvency requirements; and

(iv) the prevailing financing system in the United States and the resulting decrease in consumer price sensitivity.

(d) Nothing in this section shall preclude the commissioner from considering any factor that, in the commissioner's discretion, is relevant to the commissioner's determination. The commissioner shall have authority to issue rules and regulations and bulletins to facilitate consideration of the factors in this section.

(e) Nothing in this section shall preclude the commissioner from requesting from an insurer information or data to support these factors or factors not on this list.

New Sec. 6. Until such time as section 1312(c) "single risk pool" of the patient protection and affordable care act is fully in effect in the state, an insurer shall pool the experience of a closed block of business with all appropriate blocks of business that are not closed for the purpose of determining the premium rate of any policy within the closed block, with no rate penalty or surcharge beyond that which reflects the experience of the combined pool. A "closed block of business" is a policy or group of policies that are no longer being marketed or sold by the insurer, or that has less than 500 in-force contracts in this state, or for which enrollment has dropped by more than 12% since the last rate filing.

New Sec. 7. (a) If the commissioner approves a rate change, the commissioner shall provide written notice to the insurer that rates have been approved. Upon receipt of a notice of approval, the insurer shall send written notice by first class mail to all policyholders affected by the rate change. The notice shall inform policyholders in size 16-point font in bold the actual dollar amount of the approved premium rate increase for the policyholder, the specific percentage by which the current premium will be increased for the policyholder, the effective date of the new rate, and shall describe in plain, understandable terms any changes in plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions or conditions, and highlight this information by printing in 16-point font in bold. The notice shall also

provide information about public programs, including but not limited to medicaid, high risk pools, and CHIP.

(b) No approved rate shall be effective less than 60 days from a policyholder's receipt of the notice required under this section.

New Sec. 8. (a) At any time during the 60-day public comment period required under section 4, and amendments thereto, the commissioner shall issue an order scheduling a public hearing on the proposed rate change if:

(1) A consumer or the consumer's representative or a consumer advocacy group requests a hearing within 45 days of the opening of the public comment period. Any person requesting a hearing under this subsection shall submit the request in writing. Upon receiving a request, the commissioner shall decide within 15 days whether to grant the hearing and if the commissioner decides not to grant the hearing, the commissioner shall issue written findings in support of that decision;

(2) the commissioner, in the commissioner's discretion, determines to hold a hearing;

(3) the proposed rate change is "unreasonable" under the federal patient protection and affordable care act;

(4) the attorney general requests a hearing;

(5) the consumer advocate responsible for reviewing rate filings under section 9, and amendments thereto, requests a hearing; or

(6) if the rate request exceeds 10%, or the proposed rate change would result in an annual increase exceeding 10%.

(b) (1) Hearings shall be conducted pursuant to the Kansas administrative procedure act. Notwithstanding any provision of the Kansas administrative procedure act to the contrary, the presiding officer shall take judicial notice of the public comments received during the hearing or the public comment period. This provision shall not be read to preclude any other judicial notice.

(2) The commissioner shall provide notice of the hearing not less than 14 days prior to the hearing. The notice shall be prominently published on the department's website, in the Kansas register and in a newspaper or newspapers having aggregate general circulation throughout the state at least 14 days prior to the hearing. The notice shall contain a description of the rates proposed to be charged, and a copy of the notice shall be sent to the insurer. In addition, the insurer shall provide by first class mail, at least 14 days prior to the public hearing, notice of the public hearing to all affected policyholders. The notice shall:

(A) Describe the proposed rate change. The public notice shall also provide information on opportunities for the public to provide comment on the proposal to the commissioner; and

(B) be published in all languages spoken by 5% or more of the

policyholders, or 1,000 people in the service area, whichever is less;

(3) all documents, public comments, and correspondence with the department submitted as part of the hearing shall be deemed to be public records;

(4) the commissioner shall provide prompt and reasonable access to the records concerning the proposed rate request to the public at no charge. The records shall be considered public records and be posted on the commissioner's website;

(5) the commissioner may contract with actuaries or subject matter experts, or any combination thereof to assist the commissioner in conducting the review or hearing required under this act. The actuary or other expert shall serve under the direction of the commissioner. The commissioner is exempt from the provisions of applicable state laws regarding public bidding procedures for purposes of entering into contracts pursuant to this subsection;

(6) the insurer requesting changes in rates shall underwrite the reasonable expenses of the commissioner in connection with the hearing, including, but not limited to, any costs related to advertisements, stenographic reporting and expert witness fees.

New Sec. 9. (a) There is hereby established within the department a consumer advocate who shall represent and advocate on behalf of the interests of health insurance policyholders and members. The goal of the consumer advocate shall be to obtain the lowest possible rates for health insurance consistent with protection of insurer solvency.

(b) Any request rate increase greater than 10%, or resulting in an annual increase of greater than 10%, shall be reviewed by the consumer advocate. The consumer advocate may employ legal assistants, experts and actuaries necessary to carry out its function of advocating on behalf of policyholders and members. The commissioner shall ensure that such personnel and assistance are provided at a level sufficient to ensure that policyholder and member interests are effectively represented in all proceedings under this act.

New Sec. 10. (a) The commissioner, on timely application shall allow any person with an interest in the outcome of a proposed rate change to intervene as a party to that proceeding. Any policyholder, insured member, consumer advocate, and community representative shall all be considered persons with an interest. Any person whose interest is determined to be affected may present evidence, examine and cross-examine witnesses, and offer oral and written arguments, and in connection therewith may conduct discovery proceedings in the same manner as is allowed in the court of this state. The specific intervention provisions of this act shall control in the event of a conflict with the requirements of the Kansas administrative procedure act.

(b) This section shall not limit the power of the commissioner to consolidate parties with similar interests for the purpose of intervention.

(c) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that:

(1) The person represents the interests of consumers; and

(2) that the person has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court.

(d) The insurer requesting changes in rates shall underwrite the reasonable expenses of the commissioner in connection with the hearing, including any costs related to advertisements, stenographic reporting and expert witness fees.

(e) Any final action by the insurance commissioner shall be subject to judicial review in accordance with the provisions of the judicial review act.

New Sec. 11. (a) For the purposes of this act:

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

(2) "Department" means the insurance department.

(3) "Insurer" shall have the meaning ascribed to the term "health insurer" in K.S.A. 40-4602, and amendments thereto.

(b) This act shall be known and may be cited as the individual market health insurance rate review act.

Sec. 12. K.S.A. 2010 Supp. 40-2215 is hereby amended to read as follows: 40-2215. (a) ~~No~~*Except as provided in the individual market health insurance rate review act, and amendments thereto, 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) All parties in the filing process shall act in good faith and with due diligence in *the* performance of their duties pursuant to this section.

(f) (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) 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) 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) for the review of policy forms.

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

Sec. 13. K.S.A. 2010 Supp. 40-2215 is hereby repealed.

Sec. 14. This act shall take effect and be in force from and after its publication in the statute book.