SENATE BILL No. 65

By Committee on Financial Institutions and Insurance

1-27

AN ACT concerning health insurance; pertaining to review of health care decisions; amending K.S.A. 40-22a13, 40-22a14 and 40-22a15 and repealing the existing sections.

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

Section 1. K.S.A. 40-22a13 is hereby amended to read as follows: 40-22a13. On and after ~~January 1, 2000~~*July 1, 2011*, for the purposes of K.S.A. 40-22a13 through 40-22a16*,* and amendments thereto:

(a) "Adverse decision" means a utilization review determination by a third-party administrator, a health insurance plan, an insurer or a health care provider acting on behalf of an insured that a proposed or delivered health care service which would otherwise be covered under an insured's contract is not or was not medically necessary or the health care treatment has been determined to be experimental or investigational and~~,~~*:*

(1) If the requested service is provided in a manner that leaves the insured with a financial obligation to the provider or providers of such services~~,~~*;* or

(2) the adverse decision is the reason for the insured not receiving the requested services.

(b) "Emergency medical condition" means*:*

(1) The sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place a person's health in serious jeopardy~~.~~*;*

(2) a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function; or

(3) a medical condition for which coverage has been denied based on a determination that the recommended or requested health care service or treatment is experimental or investigational, if the insured's treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

(c) "External review organization" means an entity that conducts

independent external reviews of adverse decisions pursuant to a contract with the commissioner. Such entity shall have experience serving as the external quality review organization in health programs administered by the state of Kansas, or be a nationally accredited external review organization which utilizes health care providers actively engaged in the practice of their profession in the state of Kansas who are qualified and credentialed with respect to the health care service review. In the event no Kansas providers are qualified and credentialed with respect to the review of any case, the external review organization shall have the discretion to employ health care providers who actively engage in such health care provider's practice outside the state of Kansas.

(d) "Health insurance plan" 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.

(e) "Insured" means the beneficiary of any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, municipal group-funded pool, and the self-funded coverage established by the state of Kansas, or any hospital or medical expense, health, hospital or medical service corporation contract or a plan provided by a municipal group-funded pool.

(f) "Insurer" means any health insurance company, fraternal benefit society, health maintenance organization, nonprofit hospital and medical service corporation, provider sponsored organizations, municipal group-funded pool and the self-funded coverage established by the state of Kansas for its employees.

Sec. 2. K.S.A. 40-22a14 is hereby amended to read as follows: 40-22a14. On and after January 1, 2000:

(a) The provisions of K.S.A. 40-22a13 through 40-22a16*,* and amendments thereto*,* shall not apply to any policy or certificate which provides coverage for any specified disease, specified accident or accident only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance as defined by K.S.A. 40-227, and amendments thereto, vision care or any other limited supplemental benefit nor to any medicare supplement policy of insurance as defined by the commissioner of insurance by rule and regulation, coverage under a plan through medicare, medicaid, or the federal employees health benefits program, any coverage issues as a supplement to liability insurance, workers compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual

basis.

(b) The right to external review under K.S.A. 40-22a13 through 40-22a16, and amendments thereto, shall not be construed to change the terms of coverage under a health insurance plan or insurance policy.

(c) The insurer or health insurance plan shall provide written notice to the insured of a final adverse decision and the opportunity for requesting an external review.

(d) *(1)* The insured has the right to request an independent external review of an adverse decision by a health insurance plan or insurer when:

~~(1)~~*(A)* The insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has an emergency medical condition, in which case an expedited procedure is used; or

~~(2)~~*(B)* the insured has not received a final decision from the insurer within 60 days of seeking the internal review, except to the extent that the delay was requested by the insured.

(2) Whenever an insurer or health insurance plan fails to strictly adhere to all appeal procedure requirements as prescribed by state or federal law, the claimant shall be deemed to have exhausted the internal claims and appeal process regardless of whether such insurer or health insurance plan asserts that:

(A) It has substantially complied with such appeal procedure; or

(B) any error it committed was de minimis.

(e) Within ~~90~~*120* days of receipt of an adverse decision by a health insurance plan or an insurer, any request for external review shall be made in writing to the commissioner from the following persons: (1) The insured; (2) the treating physician or health care provider acting on behalf ~~on~~*of* the insured with written authorization from the insured; or (3) a legally authorized designee of the insured.

(f) The insured shall provide all information in the possession of the insured pertaining to the adverse decision in order for the commissioner to make a preliminary determination for an external review. The insured also shall provide the commissioner with an appeal form, and a fully executed release for the commissioner and the external review organization to obtain any necessary medical records from the insurer or health insurance plan and any other relevant provider.

(g) In responding to the commissioner, the insurer or health insurance plan shall provide a copy of the adverse decision given to the insured and all medical and other records pertaining to the insured's claim within five business days of the request of the commissioner.

(h) The confidentiality of any medical information submitted by the insured, on behalf of the insured, insurer or health insurance plan, shall be maintained pursuant to applicable state and federal laws.

Sec. 3. K.S.A. 40-22a15 is hereby amended to read as follows: 40-22a15. On and after January 1, 2000:

(a) The commissioner shall:

(1) Negotiate contracts with external review organizations which are eligible to conduct independent review of the adverse decision by a health insurance plan or insurer;

(2) allow the insurer or the health insurance plan, an insured or treating physician or health care provider acting on behalf of the insured, or legally authorized designee filing a request for external review to provide additional written information as may be relevant for the commissioner to make a final decision on whether the request qualified for external review;

(3) make a decision on a request for external review within 10 business days after receiving all necessary information;

(4) notify the insured and treating physician or health care provider acting on behalf of the insured, or legally authorized designee, and insurer or health insurance plan in writing that a request for external review will or will not be granted; and

(5) design and implement an expedited procedure for use in an emergency medical condition for purposes of the external review organization rendering a decision.

(b) The external review organization as defined in subsection (c) of K.S.A. 40-22a13, and amendments thereto, shall provide that all reviews completed pursuant to K.S.A. 40-22a13 through 40-22a16, and amendments thereto, are conducted by qualified and credentialed health care providers with respect to the health care service under review and who have no conflict of interest relating to the performance of the external review organization's duties in K.S.A. 40-22a13 through 40-22a16, and amendments thereto.

(c) The external review organization shall issue a written decision to the insured and concurrently send a copy of such decision to the commissioner including the basis and rationale for its decision within 30 business days. The standard of review shall be whether the health care service denied by the insurer or health insurance plan was medically necessary under the terms of the insured's contract. In reviews regarding experimental or investigational treatment, the standard of review shall be whether the health care service denied by the insurer or health insurance plan was covered or excluded from coverage under the terms of the insured's contract.

(d) The external review organization shall provide expedited resolution when an emergency medical condition exists, and shall resolve all issues within ~~seven business days~~*not more than 72 hours after the date of receipt of the request for an expedited external review, or as*

1 *expeditiously as the insured's medical condition or circumstances require*.
2 (e) The external review organization shall maintain and report such
3 data as may be required by the commissioner in order to assess the
4 effectiveness of the external review process.
5 (f) No external review organization nor any individual working on
6 behalf of such organization shall be liable in damages to any insured,
7 health insurance plan or insurer for any opinion rendered as part of an
8 external review conducted pursuant to K.S.A. 40-22a13 through 40-
9 22a16, and amendments thereto.
10 (g) The external review organization shall maintain confidentiality
11 of the medical records of the insured in accordance to state and federal
12 law.
13 Sec. 4. K.S.A. 40-22a13, 40-22a14 and 40-22a15 are hereby
14 repealed.
15 Sec. 5. This act shall take effect and be in force from and after its
16 publication in the statute book.
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