Kansas Legislature

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Session of 1999

SENATE BILL No. 3

An Act relating to insurance; concerning the regulation thereof; amending K.S.A. 8-173
and K.S.A. 1998 Supp. 40-2,103, as amended by section 5 of 1999 Senate Bill 108, 40-19c09, as amended by section 6 of 1999 Senate Bill 108, 40-3104 and 40-3118 and repealing the existing sections; also repealing K.S.A. 1998 Supp. 40-1909.

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

New Section 1. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, also, shall provide coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:

(1) A child five years of age and under; or

(2) a person who is severely disabled; or

(3) a person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

(b) A policy, provision, contract, plan or agreement may:

(1) Apply to the covered procedures under this section the same deductibles, coinsurance, network requirements and other limitations, including but not limited to medical necessity determinations, as apply to other covered services;

(2) require prior authorization for hospitalization for the covered procedures under this section in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions.

(c) The provisions of this section shall not apply to any policy or certificate providing coverage for any specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care, as defined by K.S.A. 40-2227, and amendments thereto, medicare supplement, as defined by the commissioner of insurance by rules and regulations, vision care or other limited-benefit supplemental insurance, nor any coverage issued 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.

(d) Nothing herein shall be construed to require any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, fraternal benefit society or health maintenance organization to provide benefits for any dental procedures.

(e) The provisions of this section shall apply to the state health care benefits program and municipal self-funded pools.

(f) As used in this section "medical care facility" shall have the meaning ascribed to the term in K.S.A. 65-425, and amendments thereto.

New Sec. 2. (a) Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hos-

pital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 1999, and which provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Such coverage shall be provided in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

(b) Each individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services which provides medical and surgical benefits with respect to a mastectomy shall provide written notice, as currently required, to all enrollees, insureds or subscribers regarding the coverage required by this section.

(c) No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services which provides medical and surgical benefits with respect to a mastectomy shall:

(1) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and

(2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) The provisions of this section 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. 40-2227 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, any coverage issued 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.

Sec. 3. K.S.A. 1998 Supp. 40-2,103, as amended by section 5 of 1999 Senate Bill 108, is hereby amended to read as follows: 40-2,103. The requirements of K.S.A. 40-2,100, 40-2,101, 40-2,102, 40-2,104, 40-2,105, 40-2,114 and 40-2250, and amendments thereto and K.S.A. 1998 Supp. 40-2,160 *and sections 1 through 4 of 1999 Senate Bill 108, and section 1 and section 2 of this act, and amendments thereto,* shall apply to all insurance policies, subscriber contracts or certificates of insurance delivered, renewed or issued for delivery within or outside of this state or used within this state by or for an individual who resides or is employed in this state.

Sec. 4. K.S.A. 1998 Supp. 40-19c09, as amended by section 6 of 1999 Senate Bill 108, is hereby amended to read as follows: 40-19c09. (a) Corporations organized under the nonprofit medical and hospital service cor-

poration act shall be subject to the provisions of the Kansas general corporation code, articles 60 to 74, inclusive, of chapter 17 of the Kansas Statutes Annotated, applicable to nonprofit corporations, to the provisions of K.S.A. 40-214, 40-215, 40-216, 40-218, 40-219, 40-222, 40-223, 40-224, 40-225, 40-226, 40-229, 40-230, 40-231, 40-235, 40-236, 40-237, 40-247, 40-248, 40-249, 40-250, 40-251, 40-252, 40-254, 40-2,100, 40-2,101, 40-2,102, 40-2,103, 40-2,104, 40-2,105, 40-2,116, 40-2,117, 40-2a01 *et seq.*, 40-2111 to 40-2116, inclusive, 40-2215 to 40-2220, inclusive, 40-2221a, 40-2221b, 40-2229, 40-2230, 40-2250, 40-2251, 40-2253, 40-2254, 40-2401 to 40-2421, inclusive, and 40-3301 to 40-3313, inclusive, K.S.A. 1998 Supp. 40-2,153, 40-2,154, 40-2,160, 40-2,161, 40-2,163 ~~and~~, 40-2,164 *and sections 1 through 4 of 1999 Senate Bill 108, and section 1 and section 2 of this act*, and amendments thereto, except as the context otherwise requires, and shall not be subject to any other provisions of the insurance code except as expressly provided in this act.

(b) No policy, agreement, contract or certificate issued by a corporation to which this section applies shall contain a provision which excludes, limits or otherwise restricts coverage because medicaid benefits as permitted by title XIX of the social security act of 1965 are or may be available for the same accident or illness.

(c) Violation of subsection (b) shall be subject to the penalties prescribed by K.S.A. 40-2407 and 40-2411, and amendments thereto.

New Sec. 5. (a) After July 1, 1999, in addition to the requirements of K.S.A. 40-2248 and 40-2249, and amendments thereto, any new mandated health insurance coverage for specific health services, specific diseases or for certain providers of health care services approved by the legislature shall apply only to the state health care benefits program, K.S.A. 75-6501, *et seq.*, and amendments thereto, for a period of at least one year beginning with the first anniversary date of the state health care benefits program subsequent to approval of the mandate by the legislature. On or before March 1, after the one year period for which the mandate has been applied, the Kansas state employees health care commission shall submit to the president of the senate and to the speaker of the house of representatives, a report indicating the impact such mandated coverage has had on the state health care benefits program, including data on the utilization and costs of such mandated coverage. Such report shall also include a recommendation whether such mandated coverage should continue for the state health care benefits program or whether additional utilization and cost data is required.

(b) The legislature shall periodically review all health insurance coverages mandated by state law.

New Sec. 6. On and after January 1, 2000, for the purposes of sections 6 through 9 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 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.

(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.

New Sec. 7. On and after January 1, 2000:

(a) The provisions of sections 6 through 9 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 sections 6 through 9, 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) The insured has the right to request an independent external review of an adverse decision by a health insurance plan or insurer when: (1) 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) 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.

(e) Within 90 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 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.

New Sec. 8. 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 section 6, and amendments thereto, shall provide that all reviews completed pursuant to sections 6 through 9, 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 sections 6 through 9, 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.

(e) The external review organization shall maintain and report such data as may be required by the commissioner in order to assess the effectiveness of the external review process.

(f) No external review organization nor any individual working on behalf of such organization shall be liable in damages to any insured, health insurance plan or insurer for any opinion rendered as part of an external review conducted pursuant to sections 6 through 9, and amendments thereto.

(g) The external review organization shall maintain confidentiality of the medical records of the insured in accordance to state and federal law.

New Sec. 9. On and after January 1, 2000:

(a) The decision of the external review organization may be reviewed directly by the district court at the request of either the insured, insurer or health insurance plan. The review by the district court shall be *de novo*. The decision of the external review organization shall not preclude the insured, insurer or health insurance plan from exercising other available

remedies applicable under state or federal law. Seeking a review by the district court or any other available remedies exercised by the insured, insurer or health insurance plan after the decision of the external review organization will not stay the external review organization's decision as to the payment or provision of services to be rendered during the pendency of the review by the insurer or health insurance plan. All material used in an external review and the decision of the external review organization as a result of the external review shall be deemed admissible in any subsequent litigation.

(b) In no event shall more than one external review be available during the same year for any request arising out of the same set of facts. An insured may not pursue, either concurrently or sequentially, an external review process under both a federal and state law. In the event external review processes are available pursuant to federal law and this act, the insured shall have the option of designating which external review process will be utilized.

(c) The commissioner of insurance is hereby authorized to negotiate and enter into contracts necessary to perform the duties required by sections 6 through 9, and amendments thereto.

(d) The commissioner of insurance shall adopt rules and regulations necessary to carry out the purposes of sections 6 through 9, and amendments thereto. The rules and regulations shall ensure that the commissioner is able to provide for an effective and efficient external review of health care services.

Sec. 10. On and after January 1, 2000, K.S.A. 8-173 is hereby amended to read as follows: 8-173. (a) An application for registration of a vehicle as provided in article 1 of chapter 8 of the Kansas Statutes Annotated and amendments thereto, shall not be accepted unless the person making such application shall exhibit:

The rest of the law is Not relevant to dental issues

(1) A receipt showing that such person has paid all personal property taxes levied against such person for the preceding year, including taxes upon such vehicle, except that if such application is made before June 21 such receipt need show payment of only one-half the preceding year's tax; or

(2) evidence that such vehicle was assessed for taxation purposes by a state agency, or was assessed as stock in trade of a merchant or manufacturer or was exempt from taxation under the laws of this state.

(b) An application for registration of a vehicle as provided in article 1 of chapter 8 of the Kansas Statutes Annotated shall not be accepted if the records of the county treasurer show that the applicant is delinquent and owes personal property taxes levied against the applicant for any preceding year.

(c) An application for registration or renewal of registration of a motor vehicle shall not be accepted until the applicant signs a certification, provided by the director of motor vehicles, certifying that the applicant has and will maintain, during the period of registration, the required insurance, self insurance or other financial security required pursuant to K.S.A. 40-3104 and amendments thereto.

(d) An application for registration or renewal of registration of a vehicle shall not be accepted if the applicant is unable to provide proof of the insurance, self insurance or other financial security required by article 31 of chapter 40 of the Kansas Statutes Annotated. Proof of insurance shall be verified by examination of the insurance card issued by an insurance company, a certificate of self insurance issued by the commissioner, a binder of insurance, a certificate of insurance, a motor carrier identification number issued by the state corporation commission, proof of insurance for vehicles covered under a fleet policy, a commercial policy covering more than one vehicle or a policy of insurance required by K.S.A. 40-3104, and amendments thereto and for vehicles used as part of a drivers education program, a dealership contract and a copy of a motor vehicle liability insurance policy issued to a school district or accredited nonpublic school. Examination of a photocopy of any of these documents shall suffice for verification of mail registration or renewals.

Sec. 11. On and after January 1, 2000, K.S.A. 1998 Supp. 40-3104 is hereby amended to read as follows: 40-3104. (a) Every owner shall pro-

(k) Whenever any person has made application for insurance coverage and such applicant has submitted payment or partial payment with such application, the insurance company, if payment accompanied the application and if insurance coverage is denied, shall refund the unearned portion of the payment to the applicant or agent with the notice of denial of coverage. If payment did not accompany the application to the insurance company but was made to the agent, the agent shall refund the unearned portion of the payment to the applicant upon receipt of the company's notice of denial.

(l) For the purpose of this act, "declination of insurance coverage" means a final denial, in whole or in part, by an insurance company or agent of requested insurance coverage.

Sec. 13. K.S.A. 1998 Supp. 40-2,103, as amended by section 5 of 1999 Senate Bill 108, 40-1909 and 40-19c09, as amended by section 6 of 1999 Senate Bill 108, are hereby repealed.

Sec. 14. On and after January 1, 2000, K.S.A. 8-173 and K.S.A. 1998 Supp. 40-3104 and 40-3118 are hereby repealed.

Sec. 15. This act shall take effect and be in force from and after its publication in the statute book.

I hereby certify that the above BILL originated in the SENATE, and passed that body

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SENATE adopted
Conference Committee Report ______________________

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President of the Senate

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Secretary of the Senate

Passed the HOUSE
as amended ______________________
HOUSE adopted
Conference Committee Report ______________________

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Speaker of the House

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Chief Clerk of the House

APPROVED ______________________

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Governor