Session of 2015

HOUSE BILL No. 2204

By Committee on Health and Human Services

2-2

AN ACT concerning insurance; enacting the claim information reporting act; providing for short-term medical plans; amending K.S.A. 2014 Supp. 40-2,193 and repealing the existing section.

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

New Section 1. (a) The provisions of sections 1 through 7, and amendments thereto, shall be known and may be cited as the claim information reporting act.

(b) As used in claim information reporting act, unless the context otherwise indicates, the following terms have the following meanings:

(1) "Employer" has the meaning assigned by 29 U.S.C. § 1002(5).

(2) "Governmental entity" means a state agency or political subdivision of this state.

(3) "Group health plan" has the meaning assigned by K.S.A. 40-2118, and amendments thereto. "Group health plan" does not include disability income or long-term care insurance.

(4) "Health insurance issuer" means any insurance company, nonprofit medical and hospital service corporation, municipal group-funded pool, fraternal benefit society, health maintenance organization or any other entity which offers a group health plan.

(5) "Plan" means an employee welfare benefit plan as defined by 29 U.S.C. § 1002(1).

(6) "Plan administrator" means an administrator as defined by 29 U.S.C. § 1002(16)(A).

(7) "Plan sponsor" has the meaning assigned by 29 U.S.C. § 1002(16)(B).

(8) "Political subdivision" means a county, municipality, school district, special-purpose district or other subdivision of state government that has jurisdiction limited to a geographic portion of the state.

(9) "Protected health information" has the meaning assigned by 45 C.F.R. § 160.103.

(b) A reference to a federal statute or regulation under subsection (a) means that statute or regulation as it existed on September 1, 2007.

New Sec. 2. (a) In addition to private entities, this act applies to a governmental entity that enters into a contract with a health insurance issuer that results in the health insurance issuer delivering, issuing for

delivery or renewing a group health plan.

(b) For purposes of this act, a health insurance issuer shall treat a governmental entity described by subsection (a) as a plan sponsor or plan administrator.

(c) A report of claim information provided under this section to a governmental entity is confidential and exempt from public disclosure under K.S.A. 45-215 et seq., and amendments thereto. The provisions of this subsection shall expire on July 1, 2020, unless the legislature reviews and reenacts this provision pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2020.

New Sec. 3. (a) Not later than the 21st day after the date a health insurance issuer receives a written request for a written report of claim information from a plan, plan sponsor or plan administrator, the health insurance issuer shall provide the requesting party the report, subject to subsections (d), (e) and (f). The health insurance issuer is not obligated to provide a report under this subsection regarding a particular employer or group health plan more than twice in any 12-month period.

(b) A health insurance issuer shall provide the report of claim information under subsection (a):

(1) In a written report;

(2) through an electronic file transmitted by secure electronic mail or a file transfer protocol site; or

(3) by making the required information available through a secure website or web portal accessible by the requesting plan, plan sponsor or plan administrator.

(c) A report of claim information provided under subsection (a) must contain all information available to the health insurance issuer that is responsive to the request made under subsection (a), including, subject to subsections (d), (e) and (f), protected health information, for the 24-month period preceding the date of the report or the period specified by paragraphs (4), (5) and (6), if applicable, or for the entire period of coverage, whichever period is shorter. Subject to subsections (d), (e) and (f), a report provided under subsection (a) must include:

(1) Aggregate paid claims experience by month, including claims experience for medical and pharmacy benefits, as applicable;

(2) total premium paid by month;

(3) total number of covered employees on a monthly basis by coverage tier, including whether coverage was for:

(A) An employee only;

(B) an employee with dependents only;

(C) an employee with a spouse only; or

(D) an employee with a spouse and dependents;

(4) the total dollar amount of claims pending as of the date of the

report;

(5) a separate description and individual claims report for any individual whose total paid claims exceed $15,000 during the 12-month period preceding the date of the report, including the following information related to the claims for that individual:

(A) A unique identifying number, characteristic or code for the individual;

(B) the amounts paid;

(C) dates of service; and

(D) applicable procedure codes and diagnosis codes; and

(6) for claims that are not part of the report described by paragraphs (1) through (5), a statement describing precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report.

(d) A health insurance issuer may not disclose protected health information in a report of claim information provided under this section if the health insurance issuer is prohibited from disclosing that information under another state or federal law that imposes more stringent privacy restrictions than those imposed under federal law under the health insurance portability and accountability act of 1996 (public law 104-191). To withhold information in accordance with this subsection, the health insurance issuer must:

(1) Notify the plan, plan sponsor or plan administrator requesting the report that information is being withheld; and

(2) provide to the plan, plan sponsor or plan administrator a list of categories of claim information that the health insurance issuer has determined are subject to the more stringent privacy restrictions under another state or federal law.

(e) A plan sponsor is entitled to receive protected health information under subsections (c)(5) and (c)(6) and section 4, and amendments thereto, only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification substantially similar to the following certification:

"I hereby certify that the plan documents comply with the requirements of 45 C.F.R. §164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions."

(f) A plan sponsor that does not provide the certification required by subsection (e) is not entitled to receive the protected health information described by subsections (c)(5) and (c)(6) and section 4, and amendments thereto, but is entitled to receive a report of claim information that includes the information described by subsections (c)(1) through (c)(4).

(g) In the case of a request made under subsection (a) after the date of termination of coverage, the report must contain all information available to the health insurance issuer as of the date of the report that is responsive to the request, including protected health information, and including the information described by subsections (c)(1) through (c)(6), for the period described by subsection (c) preceding the date of termination of coverage or for the entire policy period, whichever period is shorter. Notwithstanding this subsection, the report may not include the protected health information described by subsections (c)(5) and (c)(6) unless a certification has been provided in accordance with subsection (e).

New Sec. 4. (a) On receipt of the report required by section 3(a), and amendments thereto, the plan, plan sponsor or plan administrator may review the report and, not later than the 30th day after the date the report is received, may make a written request to the health insurance issuer for additional information in accordance with this section for specified individuals.

(b) With respect to a request for additional information concerning specified individuals for whom claims information has been provided under section 3, and amendments thereto, the health insurance issuer shall provide additional information on the prognosis or recovery if available and, for individuals in active case management, the most recent case management information, including any future expected costs and treatment plan, that relate to the claims for that individual.

(c) The health insurance issuer must respond to the request for additional information under this section not later than the 15th day after the date of the request under this section unless the requesting plan, plan sponsor or plan administrator agrees to a request for additional time.

(d) The health insurance issuer is not required to produce the report described by this section unless a certification has been provided in accordance with section 3(e), and amendments thereto.

New Sec. 5. A health insurance issuer that releases information, including protected health information, in accordance with this act has not violated a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing such information.

New Sec. 6. A health insurance issuer that does not comply with this act is subject to administrative penalties under chapter 40 of the Kansas Statutes Annotated, and amendments thereto.

New Sec. 7. Any increase in the minimum reinsurance deductible must be approved by the legislature.

Sec. 8. K.S.A. 2014 Supp. 40-2,193 is hereby amended to read as follows: 40-2,193. (a) For the purposes of this section:

(1) "Specially designed policy" means an insurance policy that by

design may not meet all or part of the definitions of a group or individual sickness and accident insurance policy and includes temporary sickness and accident insurance on a short-term basis.

(2) "Short-term *medical plan*" means ~~an insurance policy period of six months or 12 months, based upon policy design, which offers not more than one renewal period with or without a requirement of medical re-underwriting or medical requalification~~ *health coverage pursuant to a contract with a health insurance issuer that has an expiration date specific in the contract, taking into account any extensions that may be elected by the policyholder without the health insurance issuer's consent, that is less than 12 months after the original effective date of the contract*.

(A) Because a short-term ~~policy~~ *medical plan* addresses the special needs for temporary coverage, a short-term ~~policy~~ *medical plan* is not subject to continuation provisions of the health insurance portability and accountability act of 1996 (public law 104-191).

(B) Because a short-term ~~policy~~ *medical plan* addresses the special needs for temporary coverage, a short-term ~~policy~~ *medical plan* shall be exempt from medical loss ratio calculations associated with individual sickness and accident insurance issued within the state unless such calculation excludes any monthly administration fee associated with the sale of such ~~policy~~ *plan*.

(b) An individual eligible for coverage under K.S.A. 40-2209, and amendments thereto, may be allowed to purchase coverage under an individual, nonrenewable short-term medical plan.

(c) Short-term medical plans may be sold or renewed consecutively up to a total policy duration of 24 months.

(d) Upon offering a short-term medical plan, a health insurance issuer must provide written disclosure that such short-term medical plan is not subject to the provisions of guaranteed renewal.

(e) The termination of a short-term medical plan shall constitute a qualifying event and therefore an individual who has terminated a short-term medical plan may enroll in an individual health insurance plan pursuant to the special election rules established by any other qualifying event.

~~(b)~~ *(f)* Specially designed policies shall include policies designed to provide sickness and accident insurance for specific coverage of benefits or services that may be excluded as benefits or services cited under K.S.A. 2014 Supp. 40-2,192, and amendments thereto. Specially designed policies may include the following stand-alone policies and coverages:

(1) Chiropractic plans;

(2) acupuncture coverage plans;

(3) holistic medical treatment plans;

(4) podiatrist plans;

(5) pharmacy plans;
(6) psychiatric plans;
(7) allergy plans; and
(8) such other stand-alone plans or combinations of plans of accepted traditional and nontraditional medical practice as shall be allowable for exclusion from group or individual plans under K.S.A. 2014 Supp. 40-2,192, and amendments thereto.

~~(c)~~ *(g)* No specially designed policy shall be deemed to be included under the definition of group sickness and accident insurance, including short-term, limited-duration health insurance, issued or renewed inside or outside of this state and covering persons residing in this state.

Sec. 9. K.S.A. 2014 Supp. 40-2,193 is hereby repealed.

Sec. 10. This act shall take effect and be in force from and after its publication in the statute book.