

## **Amendments to the Insurance Code (Group Life Insurance Participation Requirements; External Review of Adverse Health Care Decision, Certain Consumer Protections; and Coverage for Children, Increasing Maximum Lifetime Benefit in the State High Risk Pool); Exclusion of Insurance Coverage for Certain Abortions**

**HB 2075** makes several amendments to the Insurance Code to delete specified participation percentages required for covered employees to place a group life insurance policy in effect, to amend certain provisions associated with the external review of an adverse decision (a denial of coverage for a proposed or delivered health care service), to provide coverage under the State High Risk Pool for children in certain instances and increase the maximum lifetime benefit for the Pool, and to provide for the exclusion of insurance coverage for and require an optional rider of coverage for certain abortions.

### ***Group Life Insurance—Policy Requirements***

Specifically, the bill amends a statute governing policy requirements for group life insurance to delete specified participation percentages required for covered employees to place a group life policy in effect. Under the bill, policy premiums could be paid by the policyholder, the insured employee, or both. The bill also deletes requirements that group life policies must cover a specified number of individuals at the date of issue. Finally, the bill deletes the limitation of coverage (50.0 percent in existing law) allowed for dependents covered under an employee's group life insurance policy.

Under prior law, employer group life insurance premiums were paid by the policyholder.

### ***External and Internal Review, Health Insurance***

The bill also amends certain provisions associated with the external review of an adverse decision (a denial of coverage for a proposed or delivered health care service).

### ***Adverse Health Care Decisions***

Specifically, the bill increases the time, from 90 to 120 days, an insured person has to request an external review. Under the law, an external review must be completed within seven business days when an emergency medical condition exists; the bill reduces that time frame to 72 hours after the date of the request for an expedited external review, or as expeditiously as the insured's medical condition or circumstances require.

The bill also expands the definition of "emergency medical condition" to include:

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- A medical condition where the time frame for completion of a standard external review would seriously jeopardize the insured's ability to regain maximum function; or
  - A medical condition for which coverage has been denied 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.

The bill also provides that when an insurer or health insurance plan has failed to strictly adhere to all internal appeal procedure requirements as prescribed by state or federal law, the claimant (insured) shall be deemed to have exhausted the internal claims and appeal process regardless of whether the insurer or the health plan asserts its substantial compliance with the appeal procedure or any error it committed was minimal.

#### ***External Review Organizations (EROs)***

The bill also provides that an External Review Organization's fees for the performance of external reviews may be paid by the Insurance Commissioner, by the insurer (health insurance company), or by the health plan. The bill states that in no event would the insured be responsible for any portion of the fees associated with the performance of external reviews.

The bill also amends the law governing External Review Organizations to:

- Clarify the frequency allowed for an external review (previously limited to one review during the same year for any request arising out of the same set of facts) to specify that external review would be limited to one external review during a period of twelve consecutive months commencing on the date of the initial request.
- Delete language allowing an insured the option of designating which external review process will be utilized (state or federal), for those instances in which external review processes are available pursuant to federal law.
- Require that, with exception for decisions of the External Review Organizations reviewed directly by the district court, the decision of the ERO is binding on the insured and the insurer or health insurance plan.

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***Kansas Uninsurable Health Insurance Plan Act— Amendments***

The bill amends the Kansas Uninsurable Health Insurance Plan Act (the Act governing the administration of the State High Risk Pool) to:

- Allow the Kansas Health Insurance Association (the Pool’s administrator) to accept children under the age of 19 who are otherwise eligible for the Pool, if no coverage is available under an individual health insurance policy for purchase in the county in which the child lives.
- Increase the statutory lifetime limit from \$2.0 million to \$3.0 million.

***Exclusion of Coverage for Certain Abortions; Optional Rider for Coverage***

The bill also requires all individual or group health insurance policies or contracts (including the municipal group-funded pool and the State Employee Health Plan) which are issued or renewed on and after July 1, 2011, to exclude coverage for abortions unless the procedure is necessary to preserve the life of the mother. The bill provides that coverage may be obtained through an optional rider for which an additional premium is paid. The bill also requires that the premium of the optional rider of coverage be calculated so that it fully covers the estimated cost of covering elective abortions (actuarial basis).

The bill further prohibits a health insurance exchange, established by either the State of Kansas or the federal government, from offering health insurance contracts, plans or policies that provide coverage for elective abortions. A health insurance exchange also will be prohibited from offering coverage for elective abortions through the purchase of an optional rider.

Provisions of the bill apply to all policies, contracts, and certificates of insurance delivered, renewed, or issued within Kansas or for an individual who resides or is employed in the state and to nonprofit medical and hospital service corporations.

***Definitions***

Among the definitions established in the provisions relating to elective abortions are:

“Abortion” is defined to mean “the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.”

“Elective” is defined to mean “an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.”

**Severability**

Further, the bill states that if the provisions of new law pertaining to the exclusion of coverage for certain abortions is held invalid, the invalid provision shall not affect other provisions or applications of the Act.