HOUSE Substitute for SENATE BILL No. 522

AN ACT concerning health insurance; providing the insured certain appeal rights regarding adverse health care decisions.

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

Section 1. (a) Every health insurance plan for which utilization review is performed shall include a description of the health insurance plan's procedures for an insured to obtain an internal appeal or review of an adverse decision. This description shall include all applicable time periods, contact information, rights of the insured and available levels of appeal. If the health insurer uses a utilization review organization, the insured shall be notified of the name of such utilization review organization. The health insurance plan shall provide an insured with written or electronic notification of any adverse decision, and a description of the health insurance plan's internal appeal or review procedure, including the insured's right to external review as provided in K.S.A. 40-22a14 and amendments thereto. The health insurance plan also shall notify the insured of the insured's right to waive the second appeal or internal review and proceed directly to the external review as provided in K.S.A. 40-22a14 and amendments thereto.

(b) If the health insurance plan contains a provision for two levels of internal appeal or review of a health care decision which is adverse to the insured, the health insurance plan shall allow the insured to voluntarily waive such insured's right to the second internal appeal or review. Such waiver shall be made in writing to the health insurance plan and shall constitute the exhaustion of all available internal appeal or review procedures within the meaning of subsection (d) of K.S.A. 40-22a14 and amendments thereto.

(c) If an insured elects to request the second internal appeal or review of a health care decision which is adverse to the insured, the insured shall have the right to appear in person before a designated representative or representatives of the health insurance plan or utilization review organization at the second internal appeal or review meeting. If a majority of the designated representatives of the health plan or utilization review organization who will be deciding the second internal appeal or review cannot be present in person, by telephone or by other electronic means, at least one of those designated representatives who will be deciding the second internal appeal or review shall be a physician and shall be present in person, by telephone or by other electronic means. No physician or other health care provider serving as a reviewer in an internal appeal or review of an adverse decision shall be liable in damages to the insured or the health insurance plan for any opinion rendered as part of the internal appeal or review.

(d) All second internal appeals or reviews shall provide that the insured has a right to:

(1) Receive from the health insurance plan or utilization review organization, upon request, copies of all documents, records and other information that are not confidential or privileged relevant to the insured's request for benefits;

(2) have a reasonable and adequate amount of time to present the insured's case to a designated representative or representatives of the health insurance plan or utilization review organization who will be deciding the second internal appeal or review;

(3) submit written comments, documents, records and other material relating to the request for benefits for the second internal appeal or review panel to consider when conducting the second internal appeal or review both before and, if applicable, at the second internal appeal or review meeting;

(4) prior to or during the second internal appeal or review meeting ask questions relevant to the subject matter of the internal appeal or review of any representative of the health insurance plan or utilization review organization serving on the internal appeal or review panel provided that such representative may respond verbally if the question is asked in person during an insured's appearance before the internal appeal or review panel or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

(5) be assisted or represented at the second internal appeal or review meeting by an individual or individuals of the insured's choice; and

(6) record the proceedings of the second internal appeal or review meeting at the expense of the insured.

(e) An insured, or the insured's authorized representative, wishing to request to appear in person before the second internal appeal or review panel consisting of the health insurance plan's or utilization review organization's designated representative or representatives shall make the request to the health insurance plan or utilization review organization within five working days before the date of the scheduled review meeting except that in the case of an emergency medical condition, such request must be made no less than 24 hours prior to the scheduled review meeting.

(f) The health insurance plan or utilization review organization shall provide the insured a written decision setting forth the relevant facts and conclusions supporting its decision within:

(1) Seventy-two hours if the second internal appeal or review involves an emergency medical condition as defined by subsection (b) of K.S.A. 40-22a13 and amendments thereto;

(2) fifteen business days if the second internal appeal or review involves a pre-service claim; and

(3) thirty days if the second internal appeal or review involves a post-service claim.

(g) For the purposes of this section:

(1) "Health insurance plan" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(2) "Insured" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(3) "Insurer" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(4) "Adverse decision" shall have the meaning ascribed to it in K.S.A. 40-22a13 and amendments thereto.

(5) "Pre-service claim" means a request for a claims decision when prior authorization of services is required.

(6) "Post-service claim" means a request for a claims decision for services that have already been provided.

(h) This section shall be a part of and supplemental to the utilization review act.

Sec. 2. 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 concurred in
HOUSE amendments ______________________

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President of the Senate.

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Secretary of the Senate.

Passed the HOUSE
as amended ______________________

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Speaker of the House.

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Chief Clerk of the House.

APPROVED ______________________

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Governor.