

HOUSE BILL No. 2501

AN ACT concerning insurance; relating to the liability of mortgage guaranty insurance companies; relating to health insurance and creditable coverage plans; relating to risk-based capital requirements; relating to genetic testing by insurance and health entities; relating to the use of credit information; amending K.S.A. 40-2259 and 40-3512 and K.S.A. 2009 Supp. 40-2c01, 40-2118, 40-5103 and 40-5104 and repealing the existing sections.

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

Section 1. K.S.A. 40-3512 is hereby amended to read as follows: 40-3512. *Unless a waiver is granted by the insurance commissioner*, a mortgage guaranty insurance company shall not at any time have outstanding a total liability, net of reinsurance, under its aggregate mortgage guaranty insurance policies exceeding ~~twenty-five (25)~~ 25 times its capital, surplus and contingency reserve. *Subject to a waiver which may be granted by the commissioner*, in the event that any mortgage guaranty insurance company has outstanding total liability exceeding ~~twenty-five (25)~~ 25 times its capital, surplus and contingency reserve, it shall cease transacting new mortgage guaranty business until such time as its total liability no longer exceeds ~~twenty-five (25)~~ 25 times its capital, surplus and contingency reserve. Total outstanding liability shall also be calculated on a consolidated basis for all mortgage guaranty insurance companies which are part of a holding company system as defined in K.S.A. 40-3302, *and amendments thereto. Upon the request of a mortgage guaranty insurance company, the commissioner may waive the requirements in this section for such time and under such conditions as the commissioner may order, except that no such waiver shall exceed two years.*

Sec. 2. K.S.A. 2009 Supp. 40-2118 is hereby amended to read as follows: 40-2118. As used in this act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them in this section:

- (a) "Administering carrier" means the insurer or third-party administrator designated in K.S.A. 40-2120, and amendments thereto.
- (b) "Association" means the Kansas health insurance association established in K.S.A. 40-2119, and amendments thereto.
- (c) "Board" means the board of directors of the association.
- (d) "Church plan" means a plan as defined under section 3(33) of the Employee Retirement Income Security Act of 1974.
- (e) "Commissioner" means the commissioner of insurance.
- (f) "Creditable coverage" means with respect to an individual, coverage of the individual under any of the following:
 - (1) A group health plan;
 - (2) health insurance coverage;
 - (3) part A or part B of Title XVIII of the Social Security Act;
 - (4) title XIX of the Social Security Act, other than coverage consisting solely of benefit under Section 1928;
 - (5) chapter 55 of Title 10, United States Code;
 - (6) a medical care program of the Indian Health Service or of a tribal organization;
 - (7) a state health benefit risk pool;
 - (8) a health plan offered under Chapter 89 of Title 5, United States Code;
 - (9) a public health plan as defined under regulations promulgated by the secretary of health and human services; ~~and~~
 - (10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(d)); *and*
 - (11) *A state children's health insurance program established pursuant to title XXI of the Social Security Act.*
- (g) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 23 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.
- (h) "Excess loss" means the total dollar amount by which claims expense incurred for any issuer of a medicare supplement policy or certificate delivered or issued for delivery to persons in this state eligible for medicare by reason of disability and who are under age 65 exceeds 65% of the premium earned by such issuer during a calendar year.
- (i) "Federally defined eligible individual" means an individual:
 - (1) For whom, as of the date the individual seeks coverage under this section, the aggregate of the periods of creditable coverage is 18 or more

months and whose most recent prior coverage was under a group health plan, government plan or church plan;

(2) who is not eligible for coverage under a group health plan, Part A or B of Title XVII of the Social Security Act, or a state plan under Title XIX of the Social Security Act, or any successor program, and who does not have any other health insurance coverage;

(3) with respect to whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud; and

(4) who ~~had been~~ *if* offered the option of continuation coverage under COBRA or under a similar program, ~~who~~ elected such continuation coverage, and ~~who~~ has exhausted such continuation coverage.

(j) “Federally defined eligible individuals for FTAA” means an individual who is:

(1) Legally domiciled in this state; and

(2) eligible for the credit for health insurance costs under section 35 of the internal revenue code of 1986.

(k) “FTAA” means federal trade adjustment assistance under the federal trade adjustment assistance reform act of 2002, public law 107-210.

(l) “Governmental plan” means a plan as defined under section 3(32) of the Employee Retirement Income Security Act of 1974 and any plan maintained for its employees by the government of the United States or by any agency or instrumentality of such government.

(m) “Group health plan” means an employee benefit plan as defined by section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides any hospital, surgical or medical expense benefits to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement or otherwise.

(n) “Health insurance” 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. “Health insurance” does not include policies or certificates covering only accident, credit, dental, disability income, long-term care, hospital indemnity, medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(o) “Health maintenance organization” means any organization granted a certificate of authority under the provisions of the health maintenance organization act.

(p) “Insurance arrangement” means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a group-funded pool, trust or third-party administrator, health care services or benefits other than through an insurer.

(q) “Insurer” means any insurance company, fraternal benefit society, health maintenance organization and nonprofit hospital and medical service corporation authorized to transact health insurance business in this state.

(r) “Medicaid” means the medical assistance program operated by the state under title XIX of the federal social security act.

(s) “Medicare” means coverage under both parts A and B of title XVIII of the federal social security act, 42 USC 1395.

(t) “Medicare supplement policy” means a group or individual policy of accident and sickness insurance or a subscriber contract of hospitals and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under section 1876 of the federal social security act (42 USC 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare.

(u) “Member” means all insurers and insurance arrangements participating in the association.

(v) “Plan” means the Kansas uninsurable health insurance plan created pursuant to this act.

(w) “Plan of operation” means the plan to create and operate the Kansas uninsurable health insurance plan, including articles, bylaws and operating rules, adopted by the board pursuant to K.S.A. 40-2119, and amendments thereto.

Sec. 3. K.S.A. 2009 Supp. 40-2c01 is hereby amended to read as follows: 40-2c01. As used in this act:

(a) “Adjusted RBC report” means an RBC report which has been adjusted by the commissioner in accordance with K.S.A. 40-2c04, and amendments thereto.

(b) “Corrective order” means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required to address a RBC level event.

(c) “Domestic insurer” means any insurance company or risk retention group which is licensed and organized in this state.

(d) “Foreign insurer” means any insurance company or risk retention group not domiciled in this state which is licensed or registered to do business in this state pursuant to article 41 of chapter 40 of the Kansas Statutes Annotated or K.S.A. 40-209, and amendments thereto.

(e) “NAIC” means the national association of insurance commissioners.

(f) “Life and health insurer” means any insurance company licensed under article 4 or 5 of chapter 40 of the Kansas Statutes Annotated or a licensed property and casualty insurer writing only accident and health insurance.

(g) “Property and casualty insurer” means any insurance company licensed under articles 9, 10, 11, 12, 12a, 15 or 16 of chapter 40 of the Kansas Statutes Annotated, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) “Negative trend” means, with respect to a life and health insurer, a negative trend over a period of time, as determined in accordance with the “trend test calculation” included in the RBC instructions defined in subsection (j).

(i) “RBC” means risk-based capital.

(j) “RBC instructions” mean the risk-based capital instructions promulgated by the NAIC, which are in effect on December 31, ~~2008~~ 2009, or any later version promulgated by the NAIC as may be adopted by the commissioner under K.S.A. 2009 Supp. 40-2c29, and amendments thereto.

(k) “RBC level” means an insurer’s company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(1) “Company action level RBC” means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(2) “regulatory action level RBC” means the product of 1.5 and its authorized control level RBC;

(3) “authorized control level RBC” means the number determined under the risk-based capital formula in accordance with the RBC instructions; and

(4) “mandatory control level RBC” means the product of .70 and the authorized control level RBC.

(l) “RBC plan” means a comprehensive financial plan containing the elements specified in K.S.A. 40-2c06, and amendments thereto. If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner’s recommendation, the plan shall be called the “revised RBC plan.”

(m) “RBC report” means the report required by K.S.A. 40-2c02, and amendments thereto.

(n) “Total adjusted capital” means the sum of:

(1) An insurer’s capital and surplus or surplus only if a mutual insurer; and

(2) such other items, if any, as the RBC instructions may provide.

(o) “Commissioner” means the commissioner of insurance.

Sec. 4. K.S.A. 40-2259 is hereby amended to read as follows: 40-2259. (a) As used in this section, “genetic screening or testing” means a laboratory test of a person’s genes or chromosomes for abnormalities,

defects or deficiencies, including carrier status, that are linked to physical or mental disorders or impairments, or that indicate a susceptibility to illness, disease or other disorders, whether physical or mental, which test is a direct test for abnormalities, defects or deficiencies, and not an indirect manifestation of genetic disorders.

(b) An insurance company, health maintenance organization, non-profit medical and hospital, dental, optometric or pharmacy ~~corporations~~ *corporation*, or a group subject to K.S.A. 12-2616 et seq., and amendments thereto, *offering group policies and certificates of coverage or individual policies providing hospital, medical or surgical expense benefits*, shall not:

(1) Require or request directly or indirectly any individual or a member of the individual's family to obtain a genetic test;

(2) require or request directly or indirectly any individual to reveal whether the individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family;

(3) condition the provision of insurance coverage or health care benefits on whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family; ~~or~~

(4) consider in the determination of rates or any other aspect of insurance coverage or health care benefits provided to an individual whether an individual or a member of the individual's family has obtained a genetic test or the results of the test, if obtained by the individual or a member of the individual's family;

(5) *require any individual, as a condition of enrollment or continued enrollment, to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual on the basis of whether the individual or a member of the individual's family has obtained a genetic test or the results of such test; or*

(6) *adjust premium or contribution amounts on the basis of whether the individual or a member of the individual's family has obtained a genetic test or the result of such test.*

(c) Subsection (b) does not apply to an insurer writing life insurance, disability income insurance or long-term care insurance coverage.

(d) An insurer writing life insurance, disability income insurance or long-term care insurance coverage that obtains information under paragraphs (1) or (2) of subsection (b), shall not:

(1) Use the information contrary to paragraphs (3) or (4) of subsection (b) in writing a type of insurance coverage other than life for the individual or a member of the individual's family; or

(2) provide for rates or any other aspect of coverage that is not reasonably related to the risk involved.

New Sec. 5. (a) (1) Notwithstanding any other law, rule or regulation, an insurer that uses credit information shall, upon written request from an applicant for insurance coverage or an insured, provide reasonable exceptions to the insurer's rates, rating classifications, company or tier placement, or underwriting rules or guidelines for a consumer who has experienced and whose credit information has been directly influenced by an extraordinary life circumstance.

(2) As used in this section "extraordinary life circumstance" means:

(A) Catastrophic event, as declared by the federal or any state government;

(B) serious illness or injury to the consumer or such consumer's immediate family member;

(C) the death of a spouse, child or parent of the insured;

(D) divorce or involuntary interruption of legally-owed alimony or support payments;

(E) identity theft;

(F) temporary loss of employment for a period of three months or more, if it results from involuntary termination;

(G) overseas military deployment; or

(H) other events as determined by the insurer.

(b) If a consumer submits a request for an exception under subsection (a), an insurer may, in its sole discretion:

(1) Require the consumer to provide reasonable written and independently verifiable documentation of the event;

(2) require the consumer to demonstrate that the event had a direct and meaningful impact on the consumer's credit information; and

(3) require such request be made no more than 60 days from the date of the application for insurance or the policy renewal.

(c) An insurer shall not be deemed to be out of compliance with any law, rule or regulation relating to underwriting, rating or rate filing as a result of granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

(d) The insurer shall provide notice to consumers that reasonable exceptions are available and information about how the consumer may inquire further.

(e)(1) Within 30 days of the insurer's receipt of sufficient documentation of an extraordinary life circumstance as the insurer may request under subsection (b), the insurer shall inform the consumer of the outcome of their request for a reasonable exception.

(2) The insurer may grant an exception despite the consumer not providing the initial request for an exception in writing or grant an exception where the consumer asks for consideration of repeated circumstances or the insurer has considered this circumstance previously.

(3) The insurer shall inform the consumer of the outcome of their request in writing.

(f) This section shall be part of and supplemental to the Kansas insurance score act.

Sec. 6. K.S.A. 2009 Supp. 40-5103 is hereby amended to read as follows: 40-5103. As used in this act:

(a) "Adverse action" means any of the following in connection with the underwriting of personal insurance:

(1) A denial or cancellation of coverage;

~~(2) anything other than the best possible rate; or~~

~~(3)~~ (2) a reduction or other unfavorable change in the terms of coverage of any insurance regardless of whether such insurance is in existence or has been applied for.

(b) "Affiliate" means any company that controls, is controlled by, or is under common control with another company.

(c) "Agent" shall have the meaning ascribed to it in subsection (k) of K.S.A. 2009 Supp. 40-4902, and amendments thereto, unless the context requires otherwise.

(d) "Applicant" means an individual who has applied to an insurer to be covered by a personal insurance policy.

(e) "Commissioner" means the commissioner of insurance and any authorized designee of the commissioner.

(f) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy. "Consumer" also includes an applicant for a personal insurance policy.

(g) "Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(h) "Credit information" means any credit related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Credit information shall not include any information which is not credit related, regardless of whether such information is contained in a credit report or in an application or is used to calculate an insurance score.

(i) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(j) "Department" means the insurance department established by K.S.A. 40-102 and amendments thereto.

(k) “Insurance score” means a number or rating that is derived from an algorithm, computer application, model, or other process that is based, in whole or in part, on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

(l) “Personal insurance” means private passenger automobile, homeowners, motorcycle, mobile homeowners and non-commercial dwelling fire insurance policies and boat, personal water craft, snowmobile and recreational vehicle policies. For the strict purposes of this act, personal insurance shall also include individually underwritten policies of farmowners.

Sec. 7. K.S.A. 2009 Supp. 40-5104 is hereby amended to read as follows: 40-5104. No insurer authorized to do business in the state of Kansas which uses credit information to underwrite or rate risks, shall:

(a) Use an insurance score that is calculated using income, address, zip code, race, religion, color, sex, disability, national origin, ancestry or marital status of the consumer as a factor.

(b) Without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subsection (a), refuse to quote, deny, cancel or refuse to renew any policy of personal insurance solely on the basis of credit information.

(c) Without consideration of any other applicable factor independent of credit information, base an insured’s renewal rates for personal insurance solely upon credit information.

(d) Without consideration of any other applicable factor independent of credit information, take an adverse action against a consumer solely because such consumer does not have a credit card account.

(e) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(1) Treat the consumer as if the applicant or insured had neutral credit information, as defined by the insurer; or

(2) exclude the use of credit information as a factor and use only other underwriting criteria.

(f) Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the personal insurance policy is first written or notice of renewal is issued.

~~(g) (1) Except as provided in paragraphs (2) and (3), use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report.~~

~~(2)~~ The insurer shall:

(A) Re-underwrite and re-rate the consumer’s personal insurance policy, at the annual renewal of such policy, based upon a current credit report or insurance score for such consumer, if requested by the consumer. Such consumer’s current credit report or insurance score shall be used if the result of the re-underwrite and re-rate reduces the consumer’s rate. Such consumer’s current credit report or insurance score shall not be used to increase the consumer’s rate. The insurer shall not be found to be in violation of rate filings by adjusting an insured’s rate in accordance with this subparagraph. Nothing in this subparagraph shall require an insurer to recalculate a consumer’s insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

(B) Have the discretion to obtain current credit information upon any renewal before the 36 months, if consistent with such insurer’s underwriting guidelines.

~~(3)~~ (2) No insurer shall be required to obtain current credit information for an insured, if:

(A) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report, if consistent with such insurer’s underwriting guidelines;

(B) credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the dis-

cretion to use credit for underwriting or rating such insured upon renewal, if consistent with such insurer's underwriting guidelines; or

(C) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(h) Use any of the following as a negative factor against a consumer in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

(1) Any credit inquiry not initiated by the consumer or any inquiry requested by the consumer for such consumer's own credit information;

(2) any inquiry relating to insurance coverage, if so identified on a consumer's credit report;

(3) any collection account with a medical industry code, if so identified on the consumer's credit report; or

(4) any additional lender inquiry beyond the first such inquiry related to the same loan purpose, if coded by the consumer reporting agency on the consumer's credit report as being from the given loan industry and made within 30 days of one another.

Sec. 8. K.S.A. 40-2259 and 40-3512 and K.S.A. 2009 Supp. 40-2c01, 40-2118, 40-5103 and 40-5104 are hereby repealed.

Sec. 9. 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 HOUSE, and passed that body

HOUSE adopted
Conference Committee Report _____

Speaker of the House.

Chief Clerk of the House.

Passed the SENATE
as amended _____

SENATE adopted
Conference Committee Report _____

President of the Senate.

Secretary of the Senate.

APPROVED _____

Governor.