

CONFERENCE COMMITTEE REPORT

MR. PRESIDENT and MR. SPEAKER: Your committee on conference on House amendments to **SB 119** submits the following report:

The Senate accedes to all House amendments to the bill, and your committee on conference further agrees to amend the bill as printed with House Committee amendments, as follows:

On page 5, following line 19, by inserting:

"Sec. 4. K.S.A. 40-247 is hereby amended to read as follows: 40-247. (a) An insurance agent or broker who acts in negotiating or renewing or continuing a contract of insurance including any type of annuity by an insurance company lawfully doing business in this state, and who receives any money or substitute for money as a premium for such a contract from the insured, whether such agent or broker shall be entitled to an interest in same or otherwise, shall be deemed to hold such premium in trust for the company making the contract. If such agent or broker fails to pay the same over to the company ~~after written demand made upon such agent or broker~~, less such agent's or broker's commission and any deductions, to which by the written consent of the company such agent or broker may be entitled, such failure shall be prima facie evidence that such agent or broker has used or applied the premium for a purpose other than paying the same over to the company.

(b) (1) An agent or broker who violates the provisions of this section shall be guilty of a:

(A) Severity level 7, nonperson felony if the value of the insurance premium is \$25,000 or more;

(B) severity level 9, nonperson felony if the value of the insurance premium is at least \$1,000 but less than \$25,000; or

(C) class A nonperson misdemeanor if the value of the insurance premium is less than

\$1,000.

(2) If the value of the insurance premium is less than \$1,000 and such agent or broker has, within five years immediately preceding commission of the crime, been convicted of violating this section two or more times shall be guilty of a severity level 9, nonperson felony.

Sec. 5. K.S.A. 40-2,125 is hereby amended to read as follows: 40-2,125. (a) If the commissioner determines after notice and opportunity for a hearing that any person has engaged or is engaging in any act or practice constituting a violation of any provision of Kansas insurance statutes or any rule and regulation or order thereunder, the commissioner may in the exercise of discretion, order any one or more of the following:

(1) Payment of a monetary penalty of not more than \$1,000 for each and every act or violation, unless the person knew or reasonably should have known such person was in violation of the Kansas insurance statutes or any rule and regulation or order thereunder, in which case the penalty shall be not more than \$2,000 for each and every act or violation;

(2) suspension or revocation of the person's license or certificate if such person knew or reasonably should have known that such person was in violation of the Kansas insurance statutes or any rule and regulation or order thereunder; or

(3) that such person cease and desist from the unlawful act or practice and take such affirmative action as in the judgment of the commissioner will carry out the purposes of the violated or potentially violated provision.

(b) If any person fails to file any report or other information with the commissioner as required by statute or fails to respond to any proper inquiry of the commissioner, the commissioner, after notice and opportunity for hearing, may impose a civil penalty of up to \$1,000, for each violation or act, along with an additional penalty of up to \$500 for each week thereafter that such report or other information is not provided to the commissioner.

(c) If the commissioner makes written findings of fact that there is a situation involving an immediate danger to the public health, safety or welfare or the public interest will be irreparably harmed by delay in issuing an order under subsection (a)(3), the commissioner may issue an emergency temporary cease and desist order. Such order, even when not an order within the meaning of K.S.A. 77-502, and amendments thereto, shall be subject to the same procedures as an emergency order issued under K.S.A. 77-536, and amendments thereto. Upon the entry of such an order, the commissioner shall promptly notify the person subject to the order that: (1) It has been entered; (2) the reasons therefor; and (3) that upon written request within 15 days after service of the order the matter will be set for a hearing which shall be conducted in accordance with the provisions of the Kansas administrative procedure act. If no hearing is requested and none is ordered by the commissioner, the order will remain in effect until it is modified or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after notice of and opportunity for hearing to the person subject to the order, shall by written findings of fact and conclusions of law vacate, modify or make permanent the order.

(d) For purposes of this section:

(1) "Person" means any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's insurer, fraternal benefit society and any other legal entity engaged in the business of insurance, rating organization, third party administrator, nonprofit dental service corporation, nonprofit medical and hospital service corporation, automobile club, premium financing company, health maintenance organization, insurance holding company, mortgage guaranty insurance company, risk retention or purchasing group, prepaid legal and dental service plan, captive insurance company, automobile self-insurer or reinsurance intermediary and any other legal entity under the jurisdiction of the commissioner. The term "person" ~~shall~~ does not include insurance agents and brokers as such terms are defined in K.S.A.

40-4902, and amendments thereto.

(2) "Commissioner" means the commissioner of insurance of this state.

Sec. 6. K.S.A. 2022 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 that 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 that the commissioner has determined are required to address an RBC level event.

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

(d) "Foreign insurer" means any insurance company or risk retention group not domiciled in this state that is licensed or registered to do business in this state pursuant to article 41 of chapter 40 of the Kansas Statutes Annotated, and amendments thereto, 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, and amendments thereto, 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, and amendments thereto, but does 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" means the risk-based capital instructions promulgated by the NAIC that are in effect on December 31, ~~2021~~ 2022, or any later version promulgated by the NAIC as may be adopted by the commissioner under K.S.A. 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 0.70 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.";

On page 9, following line 9, by inserting:

"Sec. 8. K.S.A. 40-3203 is hereby amended to read as follows: 40-3203. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in ~~subsection (n) or subsection (r) of K.S.A. 40-3202(n) or (r)~~, and amendments thereto, without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents;

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses, official capacity with the organization and biographical information for all of the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

(4) a sample or representative copy of any contract or agreement made or to be made between the health maintenance organization or medicare provider organization and any class of providers and a copy of any contract made or agreement made or to be made, excluding individual employment contracts or agreements, between third party administrators, marketing consultants or persons listed in subsection (3) and the health maintenance organization or medicare provider organization;

(5) a statement generally describing the organization, its enrollment process, its

operation, its quality assurance mechanism, its internal grievance procedures, in the case of a health maintenance organization the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation of the facilities at which ~~health care~~ healthcare services will be regularly available to enrollees in the case of staff and group practices, the type and specialty of ~~health care~~ healthcare personnel and the number of personnel in each specialty category engaged to provide ~~health care~~ healthcare services in the case of staff and group practices; and a records system providing documentation of utilization rates for enrollees. In cases other than staff and group practices, the organization shall provide a list of names, addresses and telephone numbers of providers by specialty;

(6) copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

(7) the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization or medicare provider organization;

(C) financial projections in conformity with statutory accounting practices prescribed or otherwise permitted by the department of insurance of the state of domicile for a minimum of three years ~~from the anticipated date of certification and on a monthly basis from the date of certification through one year~~ from the date of application. If the health maintenance organization or medicare provider organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter, up to a maximum of five years. All financial projections shall include:

~~(i) Monthly statements of revenue and expense for the first year on a gross dollar as well as per member per month basis, with quarters consistent with standard calendar year quarters;~~

~~(ii) quarterly Statements of revenue and expense for each subsequent year;~~

~~(iii)~~(ii) a quarterly balance sheet for each year; and

~~(iv)~~(iii) a statement and justification of assumptions;

(8) a description of the procedure to be utilized by a health maintenance organization or medicare provider organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of policy and operation of a health maintenance organization;

(B) monitoring of the quality of care provided by such organization including, as a minimum, peer review; and

(C) resolving complaints and grievances initiated by enrollees;

(9) a written irrevocable consent duly executed by such applicant, if the applicant is a nonresident, appointing the commissioner as the person upon whom lawful process in any legal action against such organization on any cause of action arising in this state may be served and that such service of process shall be valid and binding in the same extent as if personal service had been had and obtained upon said nonresident in this state;

(10) a plan, in the case of group or staff practices, that will provide for maintaining a medical records system ~~which~~ that is adequate to provide an accurate documentation of utilization by every enrollee, such system to identify clearly, at a minimum, each patient by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy, and in all other cases, evidence that contracts with providers require that similar medical records systems be in place;

(11) evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of ~~health care~~ healthcare;

(12) such other information as may be required by the commissioner to make the determinations required by K.S.A. 40-3204, and amendments thereto; and

(13) in lieu of any of the application requirements imposed by this section on a medicare provider organization, the commissioner may accept any report or application filed by the medicare provider organization with the appropriate examining agency or official of another state or agency of the federal government.

(c) The commissioner may promulgate rules and regulations the commissioner deems necessary to the proper administration of this act to require a health maintenance organization or medicare provider organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (b) to the commissioner prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner. Any modification or amendment for which the approval of the commissioner is required shall be deemed approved unless disapproved within 30 days, except the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.";

Also on page 9, in line 10, by striking "and" and inserting ", 40-247, 40-2,125,"; also in line 10, after "40-955" by inserting "and 40-3203 and K.S.A. 2022 Supp. 40-2c01"; in line 13, by striking "Kansas register" and inserting "statute book";

And by renumbering sections accordingly;

On page 1, in the title, in line 1, by striking "relating to insurance law;"; in line 2, by striking "obsolete"; also in line 2, by striking "therein" and inserting "in chapter 40 of the Kansas Statutes Annotated; specifying certain requirements of documents submitted by medicare

provider organizations and health maintenance organizations to demonstrate fiscal soundness; removing the requirement of a documented written demand for premium as part of a prima facie case; adding certain legal entities to the definition of person for purposes of violations of insurance law; updating the version of risk-based capital insurance in effect"; in line 3, by striking the first "and" and inserting ", 40-247, 40-2,125,"; also in line 3, after "40-955" by inserting "and 40-3203 and K.S.A. 2022 Supp. 40-2c01";

And your committee on conference recommends the adoption of this report.

 Conferees on part of House

 Conferees on part of Senate