Insurance: Utilization Review Organization Act; Electronic Notice; Financial Reporting of Certain Pools; Notification Requirements; Fees; SB 356

SB 356 amends the Utilization Review Organization Act and the Electronic Notice and Document Act. The bill amends provisions pertaining to certain financial reporting requirements on group-funded liability and group-funded workers compensation pools, and also removes certain notification requirements.

The bill also establishes a tiered-fee structure for financial examinations of insurance companies and societies based on the gross premiums received by such entities; amends the effective date specified in the Insurance Code for the risk-based capital (RBC) instructions; and permits title insurance agents to deposit escrow, settlement, and closing funds for real estate closings, including closings involving refinances of mortgage loans, that exceed $2,500 to be in the form of a real-time or instant payment.

Utilization Review Organization Act

The bill amends the Utilization Review Organization Act to require utilization review entities to implement and maintain a prior authorization application programming interface (API), pursuant to federal law in effect on January 1, 2028, to streamline the electronic prior authorization process.

The bill requires each utilization review entity certified under the Utilization Review Organization Act to implement and maintain a prior authorization API in accordance with 45 CFR § 156.223(b), as in effect on January 1, 2028. This requirement does not apply to a prior authorization request for the coverage of drugs as defined in federal law.

These sections are part of and supplemental to the Utilization Review Organization Act and is effective on January 1, 2028.

[*Note:* The Centers for Medicare and Medicaid Services (CMS) issued a proposed rule with a January 1, 2026, implementation date for API enhancement or development. CMS considered public comments on the proposed rule regarding the need for additional time for implementation and changed the compliance date in its final rule to January 1, 2027. The compliance date for the final rule applies to Medicare Advantage organizations and state Medicaid and Children's Health Insurance Program (CHIP) fee-for-service programs (by January 1, 2027), Medicaid managed care plans and CHIP managed care entities (beginning with the first rating period that begins on or after January 1, 2027), and qualified health plans in the federally facilitated exchanges (by the first plan year beginning on or after January 1, 2017).]

Group-funded Liability Pools; Submission of Financial Statement

The bill amends provisions pertaining to certain financial reporting requirements on group-funded liability pools. The bill increases, from 150 days to 180 days, the deadline by which a group-funded liability pool must submit a certified, independent financial statement after the end of the fiscal year whenever the Commissioner of Insurance (Commissioner) deems it necessary to examine the affairs and financial condition of a pool.

Tiered-fee Structure for Financial Examinations of Insurance Companies and Societies

The bill amends law to establish a tiered-fee structure for financial examinations of insurance companies and societies based on the gross premiums received by such entities. The bill also establishes that certain examination costs be "average and reasonable."

"Average and Reasonable" Fees

The bill requires the following examination costs be "average and reasonable":

- Full compensation for examiners' services, on a per diem basis;
- Outside consulting and data processing fees necessary to perform any examination; and
- Purchase, maintenance, and enhancement of examination equipment and computer software.

The bill specifies expenses for traveling and subsistence incurred by examiners in the performance of their services be "reasonably" necessary.

The bill requires the amount paid to perform any market regulation examination, including examination of a company or society's subsidiaries, and the *pro rata* amount to fund the purchase of examination equipment and computer software be "reasonable" and not exceed the continuing statutory collective total cap of $25,000.

"Average and reasonable" means the amount or fees that are in line with fees assessed by other people in the area where the examination occurred who have rendered similar services.

Tiered-fee Structure

The bill amends the amounts paid for examination costs to create a tiered-fee structure. The examination costs include:

- Compensation, expenses, and the employer's share of the Federal Insurance Contributions Act taxes;
- The employer's contribution to the Kansas Public Employees Retirement System;
- The self-insurance assessment for the Workers Compensation Act;
- The employer's cost of the state health care benefits program;
- A *pro rata* amount determined by the Commissioner to provide vacation and sick leave for the examiner;

- All average and reasonable outside consulting and data processing fees necessary to perform any examination; and

- An average and reasonable *pro rata* amount determined by the Commissioner to fund the purchase, maintenance, and enhancement of examination equipment and computer software.

The bill specifies the amount paid for the above costs; outside consulting and data processing fees necessary to perform any financial examination at any one company or society, including examination of the company's or society's subsidiaries, or any combination; and the *pro rata* amount to fund the purchase of examination equipment and computer software may not collectively total more than the following amounts:

- $50,000 for any insurance company or society that has less than $5.0 million in gross premiums, both direct and assumed, in the preceding calendar year;

- $75,000 for any insurance company or society that has at least $5.0 million but less than $25.0 million in gross premiums, both direct and assumed, in the preceding calendar year;

- $100,000 for any insurance company or society that has at least $25.0 million but less than $50.0 million in gross premiums, both direct and assumed, in the preceding calendar year;

- $125,000 for any insurance company or society that has at least $50.0 million but less than $100.0 million in gross premiums, both direct and assumed, in the preceding calendar year;

- $175,000 for any insurance company or society that has at least $100.0 million but less than $250.0 million in gross premiums, both direct and assumed, in the preceding calendar year;

- $250,000 for any insurance company or society that has at least $250.0 million but less than $500.0 million in gross premiums, both direct and assumed, in the preceding calendar year; or

- The actual total costs paid in connection with the examination for any insurance company or society that has at least $500.0 million in gross premiums, both direct and assumed, in the preceding calendar year.

[*Note:* Former law provided the amount paid may not collectively total more than $50,000 for any insurance company or society that has less than $200.0 million or more in gross premiums, both direct and assumed, in the preceding calendar year or not more than $500,000 for any insurance company or society that has $200.0 million or more in gross premiums, both direct and assumed, in the previous calendar year.]

Risk-based Capital Instructions; Effective Date Change

The bill amends the effective date specified in the Insurance Code for the RBC instructions promulgated by the National Association of Insurance Commissioners for property and casualty companies and for life insurance companies. The bill updates the effective date of the RBC instructions from December 31, 2022, to December 31, 2023.

Real-time or Instant Payment Deposit of Real Estate Closing Funds

The bill permits title insurance agents to deposit escrow, settlement, and closing funds for real estate closings, including closings involving refinances of existing mortgage loans, that exceed $2,500 to be in the form of a real-time or instant payment through the FedNow service operated by the federal reserve banks or The Clearing House payment company's Real-Time Payments system.

Electronic Notice and Document Act

The bill amends the Electronic Notice and Document Act to allow a plan sponsor of a health benefit plan (HBP) to authorize electronic delivery of plan documents and identification cards for insured individuals covered by an HBP. The bill adds and clarifies definitions in the Electronic Notice and Document Act. The bill also repeals a statute pertaining to the consent required to send electronic notices and documents and the exceptions to such requirements.

Definitions

The bill defines the following:

- "Health benefit plan covered person" (HBPCP) means a policyholder, subscriber, enrollee, or other individual participating in an HBP;

- "Insured" means an individual who is covered by an insurance policy, including an HBP;

- "Plan sponsor" means the:

    - Employer in the case of an employee benefit plan established or maintained by a single employer;

    - Employee organization in the case of a plan established or maintained by an employee organization; or

    - Association, committee, joint board of trustees, or similar group of representatives of the parties who establish or maintain the plan in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations.

The bill clarifies that the term "party" does not include an HBPCP. [*Note:* Continuing law defines "party" as any recipient of a notice or document required as part of an insurance transaction, including, but not limited to, an applicant, an insured, a policyholder, or an annuity contract holder.]

Consent to Electronic Delivery of Health Benefit Plan Communications

The bill allows the HBP sponsor, on behalf of HBPCPs, to provide consent to the electronic delivery of all communications related to the plan that are required by the Electronic Notice and Document Act and any health insurance identification cards. Before providing consent on behalf of an HBPCP, the bill requires a plan sponsor to confirm that the HBPCP routinely (at least once every 24 hours during the work week) uses electronic communications during the normal course of such covered person's employment.

Before the electronic delivery of any plan communications or health insurance identification cards, the HBP is required to:

- Provide the HBPCP with an opportunity to opt out of electronic delivery and to select U.S. mail as the preferred method of delivery; and

- Document satisfaction of all applicable statutory requirements regarding electronic delivery, consent, withdrawal of consent, and accessibility.

Provisions Included in Electronic Notice and Document Act

The bill makes the provisions in New Section 2 of SB 553, as passed by the Senate, regarding consent to electronic delivery of HBP communications, part of the Electronic Notice and Document Act.

Requirements for Electronic Delivery, Consent, and Withdrawal of Consent and Accessibility

The bill amends law regarding the requirements for authorized electronic delivery, storage, and presentation of notices or other required documents in an insurance transaction or that serve as evidence of insurance coverage to a party. The bill extends certain provisions to apply the following conditions for electronic delivery to both a party and an HBPCP:

- If provisions in the Electronic Notice and Document Act or applicable law expressly require verification or acknowledgment of receipt of a notice or document be provided to a party or an HBPCP, electronic delivery may be used only if the delivery method used provides verification or acknowledgment of receipt;

- The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party or an HBPCP may not be denied solely because of the failure to obtain electronic consent or confirmation of consent as required under New Section 1 of SB 553, as passed by the Senate, regarding the API;

- A withdrawal of consent by a party or HBPCP does not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party or HBPCP before the withdrawal of consent is effective. A withdrawal of consent by a party or HBPCP is effective within a reasonable period of time after receipt of the withdrawal by the insurer; and

- If after consent to electronic delivery is given by the party, a change in the hardware or software requirements needed to access or retain a notice or document delivered electronically creates a material risk that the party will be unable to access or retain a subsequent notice or document to which the consent applies, the party or HBPCP may elect to treat an insurer's failure to provide the following statements as a withdrawal of consent:

    - The revised hardware or software requirements for access to and retention of a notice or document delivered electronically; and

    - The right of the party to withdraw consent without the imposition of any undisclosed fee, condition, or consequence.

This section of the bill does not apply to a notice or document delivered electronically by an insurer before the effective date of the Electronic Notice and Document Act to a party or HBPCP who, before that date, consented to receive a notice or document in an electronic form otherwise allowed by law.

Group-funded Workers Compensation Pools

Submission of Financial Statement

The bill amends provisions pertaining to certain financial reporting requirements on group-funded workers compensation pools and also removes a notification requirement relating to termination or cancellation of a member in a group-funded workers compensation pool.

The bill increases, from 150 days to 180 days, the deadline by which group-funded workers compensation pools must submit a certified, independent financial statement after the end of the fiscal year whenever the Commissioner deems it necessary to examine the affairs and financial condition of any pool.

Changes in Notice of Cancellation or Termination

The bill also removes a requirement on group-funded workers compensation pools to provide notice to the Commissioner of a cancellation or termination of an individual member. Pool members are required to maintain coverage for 30 days or until the canceled or terminating member procures workers compensation and employer's liability coverage.

Repealed Statutes

In addition to the statutes amended, the bill repeals KSA 40-5802, which contains the consent requirements for electronic delivery of notices and documents and the exceptions to such requirements.