**304.17A-240 Renewal or continuation -- Ground for nonrenewal, cancellation, or discontinuance.**

(1) Except as provided in this section, an insurer shall renew or continue in force a health benefit plan at the option of the insured.

(2) An insurer may nonrenew, cancel, or discontinue a health benefit plan based only on one (1) or more of the following:

(a) The insured has failed to pay premiums or contributions in accordance with the terms of the plan or the insurer has not received timely premium payments;

(b) The insured has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(c) The insured has engaged in intentional and abusive noncompliance with material provisions of the health benefit plan;

(d) The insurer is ceasing to offer coverage in the individual or group market in accordance with subsection (3) of this section;

(e) In the case of an insurer that offers health benefit plans through a network plan, the individual no longer resides, lives, or works in the service area or in an area for which the insurer is authorized to do business, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals, or there is no longer any enrollee in connection with the group plan who resides, lives, or works in the service area of the insurer;

(f) In the case of a health benefit plan that is made available only through one (1) or more bona fide associations, the membership of the individual or employer in the association on the basis of which the coverage is provided ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals; or

(g) In the case of a health benefit plan issued to a group, the group no longer meets participation requirements or contribution requirements as established by the insurer.

(3) (a) In any case in which an insurer decides to discontinue offering a particular type of health benefit plan, coverage of the type may be discontinued by the insurer upon approval by the commissioner only if:

1. The insurer provides notice to each insured provided coverage of this type in the market of the discontinuation at least ninety (90) days prior to the date of the discontinuation of the coverage;

2. The insurer offers, to each insured provided coverage of this type, the option to purchase any other health benefit plan currently of that type being offered by the insurer in that market; and

3. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph 2. of this paragraph, the insurer acts uniformly without regard to any health status-related

factor of enrolled insureds or insureds who may become eligible for coverage.

(b) 1. Subject to paragraph (a)3. of this subsection, in any case in which an insurer elects to discontinue offering all health benefit plans in Kentucky, health benefit plans may be discontinued by the insurer only if:

a. The insurer provides notice to the commissioner and to each insured of the discontinuation at least one hundred eighty (180) days prior to the date of the expiration of the coverage; and

b. All health benefit plans issued or delivered for issuance in Kentucky are discontinued and coverage under the health benefit plans is not renewed.

2. In the case of a discontinuation under subparagraph 1. of this paragraph, the insurer may not provide for the issuance of any health benefit plans in Kentucky during the five (5) year period beginning on the date of the discontinuation of the last health benefit plan not so renewed.

(4) At the time of coverage renewal, an insurer may modify, with approval of the commissioner, the health benefit plan for a policy form so long as the modification is consistent with this chapter and effective on a uniform basis among all individuals with that policy form.

(5) In applying this section in the case of a health benefit plan that is made available by an insurer only through one (1) or more associations, a reference to an individual is deemed to include a reference to an association of which the individual is a member, and a reference to an employer member is deemed to include a reference to the employer.

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