CHAPTER 476

(HB 517)

AN ACT relating to health insurance.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. SUBTITLE 17B OF KRS CHAPTER 304 IS ESTABLISHED AND A NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

As used in this subtitle, unless the context requires otherwise:

(1) "Administrator" is defined in KRS 304.9-051(1);

(2) "Agent" is defined in KRS 304.9-020;

(3) "Assessment process" means the process of assessing and allocating guaranteed acceptance program losses or Kentucky Access funding as provided for in Section 11 of this Act;

(4) "Authority" means the Kentucky Health Care Improvement Authority;

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

(6) "Commissioner" is defined in KRS 304.1-050(1);

(7) "Department" is defined in KRS 304.1-050(2);

(8) "Earned premium" means the portion of premium paid by an insured that has been allocated to the insurer's loss experience, expenses, and profit year to date;

(9) "Enrollee" means a person who is enrolled in a health benefit plan offered under Kentucky Access;

(10) "Eligible individual" is defined in subsection (7) of Section 17 of this Act;

(11) "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(12) "Guaranteed acceptance program participating insurer" means an insurer that offered health benefit plans through December 31, 2000, in the individual market to guaranteed acceptance program qualified individuals;

(13) "Health benefit plan" is defined in subsection (17) of Section 17 of this Act;

(14) "High-cost condition" means acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease, chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation period for a newborn child, and low birth weight of a newborn child;

(15) "Incurred losses" means for Kentucky Access the excess of claims paid over premiums received;

(16) "Insurer" is defined in subsection (22) of Section 17 of this Act;

(17) "Kentucky Access" means the program established in accordance with Sections 1 to 16 of this Act;

(18) "Kentucky Access Fund" means the fund established in Section 11 of this Act;

(19) "Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in subsection (5) of Section 2 of this Act;

(20) "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in subsection (5) of Section 2 of this Act;

(21) "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

(22) "Medicaid" means coverage in accordance with Title XIX of the Social Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

(23) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

(24) "Pre-existing condition exclusion" is defined in KRS 304.17A-220(3);

(25) "Standard health benefit plan" means a health benefit plan that meets the requirements of Section 21 of this Act;

(26) "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(27) "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employercontrolled or bona fide associations; and

(28) "Utilization management" is defined in KRS 304.17A-500(12).

SECTION 2. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby established the Kentucky Health Care Improvement Authority as an agency, instrumentality, and political subdivision of the Commonwealth and a public body corporate and politic with all the powers, duties, and responsibilities conferred upon it by statute and necessary or convenient to carry out its functions. The authority shall be administered by a board of fifteen (15) members and is created to perform the public functions of administering programs financed by the funds appropriated to the authority in conformance with Sections 1 to 16 of this Act and any terms and conditions established by the General Assembly as a part of the act appropriating the funds. The members of the board shall consist of the following:

(a) The commissioner of the Department of Insurance, who shall serve as chair;

(b) The secretary of the Cabinet for Health Services, who shall serve as vice chair;

(c) Two (2) nonvoting members serving ex officio from the House of Representatives, one (1) of whom shall be appointed by the Speaker of the House and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(d) Two (2) nonvoting members serving ex officio from the Senate, one (1) of whom shall be appointed by the President of the Senate and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(e) The deans of the University of Louisville School of Medicine and the University of Kentucky College of Medicine;

(f) The commissioner of the Department for Public Health;

(g) Two (2) representatives of Kentucky health care providers, who shall be appointed by the Governor; and

(h) Four (4) citizens at large of the Commonwealth, who shall be appointed by the Governor.

(2) The terms of office of the initial appointments of the citizen at-large members of the board shall expire one (1), two (2), three (3), and four (4) years respectively from the expiration date of the initial appointment. One (1) of the initial terms of the representatives of health care providers, at least one (1) of whom shall be male and at least one (1) of whom shall be female, shall be for two (2) years and one (1) shall be for four (4) years. All succeeding appointments shall be for four (4) years from the expiration date of the term of the initial appointment. Two (2) of the citizens at large shall be male and two (2) shall be female. Board members shall serve until their successors are appointed.

(3) In making private sector and citizen-at-large appointments to the board, the Governor shall assure broad geographical and ethnic representation as well as representation from consumers and the major sectors of Kentucky's health care and health insurance businesses. Private sector and citizen-at-large members shall serve without compensation but shall be reimbursed for reasonable and necessary expenses.

(4) The authority shall establish priorities for programs and the expenditure of funds, establish procedures for accountability, and develop mechanisms to measure the success of programs that receive allocated funds in accordance with any criteria or instructions provided by the General Assembly. The authority shall be attached to the Department of Insurance for administrative purposes and shall establish advisory boards it deems appropriate, which shall consist of health insurance consumers, health care providers, and insurance company representatives, to assist with oversight of fund expenditures.

(5) Grants and funds obtained under Sections 1 to 16 of this Act shall be used for expenditures as follows:

(a) Seventy percent (70%) of all moneys in the fund shall be placed into the Kentucky Access fund for the purpose of funding Kentucky Access;

(b) Twenty percent (20%) of all moneys in the fund shall be spent on a collaborative partnership between the University of Louisville and the University of Kentucky dedicated to lung cancer research; and

(c) Ten percent (10%) of all moneys in the fund shall be used to discourage the use of harmful substances by minors.

(6) The authority shall assure that a public hearing is held on the expenditure of funds allocated under this section, except for funds allocated to the Kentucky Access fund.

Advertisement of the public hearing shall be published at least once but may be published two (2) more times, if one (1) publication occurs not less than seven (7) days nor more

than twenty-one (21) days before the scheduled date of the public hearing. The authority shall submit an annual report to the Governor and the General Assembly indicating how the funds were used and an evaluation of the program's effectiveness in health care and access to health insurance for Kentucky residents.

(7) Neither the authority nor its employees shall be liable for any obligations of any of the programs established under Sections 1 to 16 of this Act. No member or employee of the authority shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under Sections 1 to 16 of this Act, unless the act or omission constitutes willful or wanton misconduct. The authority may provide in its policies and procedures for indemnification of, and legal representation for, its members and employees.

(8) The authority shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of Sections 1 to 16 of this Act, including, but not limited to, retaining the staff it deems necessary for the proper performance of its duties.

(9) The authority shall meet at least quarterly and at other times upon call of the chair or a majority of the authority.

SECTION 3. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby created Kentucky Access, which shall ensure that health coverage is made available to each Kentucky individual resident applying and qualifying for coverage. Any health coverage provided under this section shall begin no sooner than January 1, 2001. Kentucky Access is designed for the purpose of implementing an acceptable alternative mechanism within the meaning of 42 U.S.C. sec. 300gg-44(a)(1) so that Kentucky may preserve the flexibility over the regulation of health coverage allowed by federal law.

(2) Kentucky Access shall operate under the supervision of the department.

(3) Neither the department nor its employees shall be liable for any obligations of Kentucky Access. No member or employee of the department shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under Sections 1 to 16 of this Act, unless such act or omission constitutes willful or wanton misconduct. The department may provide in its policies and procedures for indemnification of, and legal representation for, its members and employees.

SECTION 4. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

In its duties to operate and administer Kentucky Access, the department shall, through itself or designated agents:

(1) Establish administrative and accounting procedures for the operation of Kentucky Access;

(2) Enter into contracts as necessary;

(3) Take legal action necessary:

(a) To avoid the payment of improper claims against Kentucky Access or the coverage provided by or through Kentucky Access;

(b) To recover any amounts erroneously or improperly paid by Kentucky Access;

(c) To recover any amounts paid by the Kentucky Access as a result of mistake of fact or law;

(d) To recover other amounts due Kentucky Access; or

(e) To operate and administer its obligations under the provisions of Sections 1 to 16 of this Act;

(4) Establish, and modify as appropriate, rates, rate schedules, rate adjustments, premium rates, expense allowances, claim reserve formulas, and any other actuarial function appropriate to the administration and operation of Kentucky Access. Premium rates and rate schedules may be adjusted for appropriate factors, including, but not limited to, age and sex, and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(5) Establish procedures under which applicants and participants in Kentucky Access shall have an internal grievance process and a mechanism for external review through an independent review organization in accordance with this chapter;

(6) Select a third-party administrator in accordance with Section 6 of this Act;

(7) Require that all health benefit plans, riders, endorsements, or other forms and documents used to administer Kentucky Access meet the requirements of Subtitles 12, 14, 17, 17A, and 38 of this chapter;

(8) Adopt nationally recognized uniform claim forms in accordance with this chapter;

(9) Develop and implement a marketing strategy to publicize the existence of Kentucky Access, including, but not limited to, eligibility requirements, procedures for enrollment, premium rates, and a toll–free telephone number to call for questions;

(10) Establish and review annually provider reimbursement rates that ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under Kentucky Access at least to the extent that such care and services are available to the general population. The department shall only authorize contracts with health care providers that prohibit the provider from collecting from the enrollee any amounts in excess of copayment amounts, coinsurance amounts, deductible amounts, and amounts for noncovered services;

(11) Conduct periodic audits to assure the general accuracy of the financial and claims data submitted to the department and be subject to an annual audit of its operations;

(12) Issue health benefit plans January 1, 2001, or thereafter, in accordance with the requirements of Sections 1 to 16 of this Act;

(13) Require a referral fee of fifty dollars ($50) to be paid to agents who refer applicants who are subsequently enrolled in Kentucky Access. The referral fee shall be paid only on the initial enrollment of an applicant. Referral fees shall not be paid on any enrollments of enrollees who have been previously enrolled in Kentucky Access, or for renewals for enrollees;

(14) Bill and collect premiums from enrollees in the amount determined by the department;

(15) Assess insurers and stop-loss carriers in accordance with Section 11 of this Act;

(16) Reimburse GAP participating insurers for GAP losses pursuant to Section 11 of this Act;

(17) Establish a provider network for Kentucky Access by developing a statewide provider network or by contracting with an insurer for a statewide provider network. In the event the department contracts with an insurer, the department may take into consideration factors including, but not limited to, the size of the provider network, the composition of the provider network, and the current market rate of the provider network. The provider network shall be made available to the third-party administrator specified in Section 6 of this Act and shall be limited to Kentucky Access enrollees.

(18) Be audited by the Auditor of Public Accounts;

(19) By administrative regulation, amend the definition of high-cost conditions provided in Section 1 of this Act by adding other high-cost conditions;

(20) The department shall report on an annual basis to the Interim Joint Committee on Banking and Insurance the separation plan pursuant to Section 18 of this Act for the division of duties and responsibilities between the operation of the Department of Insurance and the operation of Kentucky Access; and

(21) Any other actions as may be necessary and proper for the execution of the department's powers, duties, and obligations under Sections 1 to 16 of this Act.

SECTION 5. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

In its duties to operate and administer Kentucky Access, the department may, through itself or third parties:

(1) Exercise any and all powers granted to insurers under this chapter; and

(2) Sue or be sued.

SECTION 6. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The department shall select a third-party administrator, through the state competitive bidding process, to administer Kentucky Access. The third-party administrator shall be an administrator licensed by the department. The department shall consider criteria in selecting a third-party administrator that shall include, but not be limited to, the following:

(a) A third-party administrator's proven ability to demonstrate performance of the operations of an insurer to include the following: enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization management, quality improvement, drug utilization review, premium billing and collection, claims payment, and data reporting;

(b) The total cost to administer Kentucky Access;

(c) A third-party administrator's proven ability to demonstrate that Kentucky Access shall be administered in a cost-efficient manner;

(d) A third-party administrator's proven ability to demonstrate experience in two (2) or more states administering a risk pool for a minimum of a three (3) year period; and (e) A third-party administrator's financial condition and stability.

(2) The department may contract with the third-party administrator for a period of four (4) years with an option for a two (2) year extension as approved by the department on a year-by-year contract basis. At least one (1) year prior to the expiration of the third-party administrator's contract, the department may solicit third-party administrators, including the current third-party administrator, to submit bids to serve as the third-party administrator for the succeeding four (4) year period.

(3) In addition to any duties and obligations set forth in the contract with the third-party administrator, the third-party administrator shall:

(a) Develop and establish policies and procedures for enrollee enrollment, eligibility determination, provider enrollment and credentialing, utilization management, case management, disease management, quality improvement, drug utilization review, premium billing and collection, data reporting, and other responsibilities determined by the department;

(b) Develop and establish policies and procedures for paying the agent referral fee under Sections 1 to 16 of this Act;

(c) Develop and establish policies and procedures to ensure timely and efficient payment of claims to include, but not limited to, the following:

1. Develop and provide a claims billing manual to health care providers enrolled in Kentucky Access that includes information relating to the proper billing of a claim and the types of claim forms to use;

2. Payment of all claims in accordance with the provisions of this chapter and the administrative regulations promulgated thereunder; and

3. Notification to an enrollee through an explanation of benefits if a claim is denied or if there is enrollee financial responsibility of a paid claim for deductible or coinsurance amounts;

(d) Issue denial letters under KRS 304.17A-540 for denial of preauthorization and precertification requests for medical necessity and medical appropriateness determinations;

(e) Submit information to the department under KRS 304.17A-330;

(f) Submit reports to the department regarding the operation and financial condition of Kentucky Access. The frequency, content, and form of the reports shall be determined by the department;

(g) Submit an annual report to the department three (3) months after the end of each calendar year. The annual report shall include:

1. Earned premium;

2. Administrative expenses;

3. Incurred losses for the year;

4. Paid losses for the year;

5. Number of enrollees enrolled in Kentucky Access by category of eligibility; and

6. Any other information requested by the department; and

(h) Be subject to examination by the department under Subtitles 2 and 3 of this chapter.

(4) The third-party administrator shall be paid for necessary and reasonable expenses, as provided in the contract between the department and the third-party administrator.

SECTION 7. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The schedule of rates, premium rates charged to enrollees, deductible amounts, copayment amounts, coinsurance amounts, and other cost-sharing amounts shall be established by the department. Premium rates charged to enrollees are not intended to fully cover the cost of providing health care coverage to Kentucky Access enrollees, and any claims in excess of premium rates shall be covered by the Kentucky Access fund.

(2) Premium rates for health benefit plans provided under Kentucky Access shall bear a reasonable relationship to each other. Premium rates shall be varied based on age and gender. The initial premium rates for plan coverage shall not exceed one hundred fifty percent (150%) of the applicable individual standard risk rates, as established by the department. In no event shall premium rates exceed one hundred seventy-five percent (175%) of the rates applicable to individual standard risks.

(3) Premium rates for coverage issued by Kentucky Access shall be established annually by the department, using reasonable actuarial principles, and shall reflect anticipated experience and expenses for risks under Kentucky Access.

SECTION 8. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Any individual who is an eligible individual is eligible for coverage under Kentucky Access, except as specified in paragraphs (a), (b), (d), and (e) of subsection (4) of this section.

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least two (2) insurers for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in Section 1 of this Act.

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3) year period and may be used by the enrollee to obtain insurance in the regular individual market.

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) The individual has, or is eligible for, on the date of application for coverage under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section. An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible for" includes any individual who was eligible for coverage but waived that coverage. That individual shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in Section 10 of this Act, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the department; or

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs.

(5) The coverage of any person who ceases to meet the requirements of this section may be terminated.

SECTION 9. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) At least annually, the department shall evaluate and revise as necessary rates to be charged to Kentucky Access enrollees.

(2) Except as provided in Section 10 of this Act, the department may revise its health benefit plans, cost-sharing arrangements, plan delivery rules, schedule of benefits, rates, and cost-containment features provided under Kentucky Access at the time of the health benefit plan renewal as necessary to ensure that Kentucky Access maintains adequate resources for continued operation.

SECTION 10. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Kentucky Access shall offer at least three (3) health benefit plans to enrollees, which shall be similar to the health benefit plans currently being marketed to individuals in the individual market. One (1) plan shall be the standard health benefit plan set forth in KRS 304.17A-250.

(2) At least one (1) plan shall be offered in a traditional fee-for-service form. At least one (1) plan may be offered in a managed-care form at such time as the department can establish an appropriate provider network in available service areas.

(3) The department shall provide for utilization review and case management for all health benefit plans issued under Kentucky Access.

(4) The department shall review and compare health benefit plans provided under Kentucky Access to health benefit plans provided in the individual market. Based on the review, the department may amend or replace the health benefit plans issued under Kentucky Access, except for the standard health benefit plan as specified in subsection (1) of this section.

(5) Individuals who apply and are determined eligible for health benefit plans issued under Kentucky Access shall have coverage effective the first day of the month after the application month.

(6) For eligible individuals, health benefit plans issued under Kentucky Access shall not impose any pre-existing condition exclusions. In all other cases, a pre-existing condition exclusion may be imposed in accordance with KRS 304.17A-230.

(7) Health benefit plans issued under Kentucky Access shall be guaranteed renewable except as otherwise specified in Section 8 of this Act and KRS 304.17A-240.

(8) All health benefit plans issued under Kentucky Access shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue under the same or a different contract.

(9) Health benefit plans issued under Kentucky Access shall coordinate benefits with other health benefit plans and be the payor of last resort.

(10) Except for the standard health benefit plan specified in subsection (1) of this section, health benefit plans issued under Kentucky Access shall pay covered benefits up to a lifetime limit of two million dollars ($2,000,000) per covered individual. The maximum limit under this subsection may be increased by the department.

SECTION 11. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) In addition to the other powers enumerated in Sections 1 to 16 of this Act, the department shall assess insurers in the amounts specified in this section. The assessment shall be used for the purpose of funding GAP losses and Kentucky Access.

(a) The amount of the assessment for each calendar year shall be as follows:

1. From each stop-loss carrier, an amount that is equal to two dollars ($2) upon each one hundred dollars ($100) of health insurance stop-loss premiums;

2. From all insurers, an amount based on the total amount of all health benefit plan premiums earned during the prior assessment period and paid by all insurers who received any of the health benefit plan premiums on which the annual assessment is based. The percentage rate used for the annual assessment shall be the same percentage rate as calculated in the GAP risk adjustment process for the six (6) month period of July 1, 1998, through December 31, 1998;

3. If determined necessary by the department, a second assessment may be assessed in the same manner as the annual assessment in subparagraph 2. of this paragraph; and

4. In no event shall the sum of the first assessment provided for in subparagraph

2. of this paragraph and the second assessment provided for in subparagraph 3. of this paragraph be greater than one percent (1%) of the total amount of all assessable health benefit plan premiums earned during the prior assessment period.

(b) The first assessment shall be for the period from January 1, 2000, through December 31, 2000, and shall be paid on or before March 31, 2001. Subsequent annual assessments shall be paid on or before March 31 of the year following the assessment period.

(2) Every supporting insurer shall report to the department, in a form and at the time as the department may specify, the following information for the specified period:

(a) The insurer's total stop-loss premiums and health benefit plan premiums in the individual, small group, large group, and association markets; and (b) Other information as the department may require.

(3) As part of the assessment process, the department shall establish and maintain the Kentucky Access fund. All funds shall be held at interest, in a single depository designated in accordance with KRS 304.8-090(1) under a written trust agreement in accordance with KRS 304.8-095. All expense and revenue transactions of the fund shall be posted to the Management Administrative Reporting System (MARS) and its successors.

(4) The Kentucky Access fund shall be funded from the following sources:

(a) Premiums paid by Kentucky Access enrollees;

(b) The funds designated for Kentucky Access in the Kentucky Health Care Improvement fund;

(c) Appropriations from the General Assembly;

(d) All premium taxes collected under KRS Chapter 136 from any insurer, and any retaliatory taxes collected under KRS 304.3-270 from any insurer, for accident and health premiums that are in excess of the amount of the premium taxes and retaliatory taxes collected for the calendar year 1997;

(e) Annual assessments from supporting insurers;

(f) A second assessment from supporting insurers;

(g) Gifts, grants, or other voluntary contributions;

(h) Interest or other earnings on the investment of the moneys held in the account; and

(i) Any funds remaining on January 1, 2001, in the guaranteed acceptance program account may be transferred to the Kentucky Access fund.

(5) The department shall determine on behalf of Kentucky Access the premiums, the expenses for administration, the incurred losses, taking into account investment income and other amounts needed to satisfy reserves, estimated claim liabilities, and other obligations for each calendar year. The department shall also determine the amount of the actual guaranteed acceptance program plan losses for each calendar year. The department shall assess insurers as follows:

(a) On or before March 31 of each year, the amount set forth in subsection (1)(a)1. and (1)(a)2. of this section.

(b) If the amount of actual guaranteed acceptance program plan losses exceeds the assessment provided for in paragraph (a) of this subsection, a second assessment shall be authorized under subsection (1)(a)3. of this section. If the amount of GAP losses exceeds the assessments provided under subsection (1)(a)1., subsection (1)(a)2., and subsection (1)(a)3. of this section, moneys received and available from the Kentucky Health Care Improvement Fund after the department determines available funding for Kentucky Access for the current calendar year pursuant to subsection (6) of this section, shall be used to reimburse GAP participating insurers for any actual guaranteed acceptance program losses. If the amount of GAP losses exceeds the amount in the Kentucky Health Care Improvement Fund after reserving sufficient funds for Kentucky Access for the current year, each GAP participating insurer shall be reimbursed up to the amount of its proportional share of actual guaranteed acceptance program plan losses from the fund. Effective for any assessment on or after January 1, 2001, in calculating GAP losses, total premiums and total claims of the GAP participating insurer shall be used. Actual guaranteed acceptance program losses shall be calculated as the difference between the total GAP claims and the total GAP premiums on an aggregate basis.

(c) If GAP losses are fully covered by the assessment process provided for in subsection (1)(a)1. and (1)(a)2. of this section and the second assessment provided for in subsection (1)(a)3. of this section is not necessary to cover GAP losses, and as determined by the department using reasonable actuarial principles Kentucky Access funding is needed, a second assessment provided for in subsection (1)(a)3. of this section shall be completed.

(6) After the end of each calendar year, GAP losses shall be reimbursed only after the department determines that appropriate funding is available for Kentucky Access for the current calendar year. GAP losses shall be reimbursed after reserving sufficient funds for Kentucky Access.

(7) With respect to a GAP participating insurer who reasonably will be expected both to pay assessments and to receive payments from the assessment fund, the department shall calculate the net amount owed to or to be received from the fund, and the department shall only collect assessments for or make payments from the fund based upon net amounts.

(8) Insurers paying an assessment may include in any health insurance rate filing the amount of these assessments as provided for in Subtitle 17A of this chapter.

(9) Insurers shall pay any assessment amounts authorized in Sections 1 to 16 of this Act within thirty (30) days of receiving notice from the department of the assessment amount.

(10) Any surpluses remaining in the Kentucky Access fund after completion of the assessment process for a calendar year shall be maintained for use in the assessment process for future calendar years and such funds shall not lapse. The general fund appropriations to the Kentucky Access fund shall not lapse.

(11) Assessments on health benefit plan premiums that are required under Sections 1 to 16 of this Act shall not be applied to premiums received by an insurer for state employees, Medicaid recipients, Medicare beneficiaries, and CHAMPUS insureds.

(12) The department shall direct that receipts of Kentucky Access be held at interest, and may be used to offset future losses or to reduce plan premiums in accordance with the terms of Sections 1 to 16 of this Act. As used in this subsection, "future losses" may include reserves for incurred but not reported claims.

(13) The department shall conduct examinations of insurers and stop-loss carriers reasonably necessary to determine if the information provided by the insurers or stop-loss carriers is accurate.

(14) The insurer, as a condition of conducting health insurance business in Kentucky, shall pay the assessments specified in Sections 1 to 16 of this Act.

(15) The stop-loss carrier, as a condition of doing health insurance business in Kentucky, shall pay the assessments specified in Sections 1 to 16 of this Act.

SECTION 12. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) After the end of each calendar year, a GAP participating insurer shall report the following information for the previous calendar year:

(a) The total earned premium in the individual, small group, large group, and association markets;

(b) The number of GAP policies in force as of December 31;

(c) The amount of the insurer's GAP premiums received during the calendar year covered by the report;

(d) The amount of the insurer's GAP claims paid during the calendar year covered by the report;

(e) The amount of the insurer's GAP losses; and

(f) Other information as the department may require to be reported.

(2) After the end of each calendar year, and based upon the reports filed under subsection (1) of this section, the department shall calculate and provide to each insurer who filed a report the following information relating to the calendar year:

(a) The amount of each reporting insurer's market share;

(b) The total amount of GAP premiums for all reporting insurers;

(c) The total amount of GAP claims paid by all reporting insurers;

(d) The amount of total actual GAP losses;

(e) The amount of the insurer's assessment or refund; and

(f) Other information as the department may elect to calculate and report.

The department shall complete its calculation and provide each insurer the results of its calculation within sixty (60) days after receiving all required information.

(3) The department shall pay GAP losses to GAP participating insurers in accordance with this section and subsection (5) of Section 11 of this Act.

(4) The department shall conduct examinations of insurers participating in Kentucky Access as are reasonably necessary to determine if the information provided by the insurers is accurate.

SECTION 13. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Any health benefit plan issued to a GAP qualified individual under the GAP program shall be renewed at the option of the enrollee, except for the reasons set out in KRS 304.17A-240.

(2) The Guaranteed Acceptance Program shall remain in effect except for KRS 304.17A-400, 304.17A-420, 304.17A-440, 304.17A-460, 304.17A-470, and 304.17A-480.

SECTION 14. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Kentucky Access and the department shall be exempt from all taxes levied by the state or any of its subdivisions.

SECTION 15. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Sixty (60) days prior to the regular session of the General Assembly in the year 2002, and sixty (60) days prior to each subsequent regular session of the General Assembly thereafter, the department shall submit a written report to the Legislative Research Commission and provide a detailed briefing. The report shall contain an evaluation of Kentucky Access, an evaluation of issues concerning high-risk individuals, and other information as the department deems necessary.

(2) Beginning no later than June 30, 2001, and annually thereafter, the Auditor of Public Accounts shall audit Kentucky Access and within sixty (60) days of completion of the audit shall submit a copy of the audit to the Legislative Research Commission and the Department of Insurance.

SECTION 16. A NEW SECTION OF SUBTITLE 17B OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The department shall promulgate administrative regulations necessary to carry out the provisions of Sections 1 to 16 of this Act.

(2) Kentucky Access shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(a) Subtitl e 1;

(b) Subtitl e 2; (c) Subtitle 3; (d) Subtitle 5; (e) Subtitle 8;

(f) Subtitle 9;

(g) Subtitle 12;

(h) Subtitle 14;

(i) Subtitle 17;

(j) Subtitle 17A;

(k) Subtitle 25;

(l) Subtitle 38; and (m) Subtitle 47.

Section 17. KRS 304.17A-005 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(3) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(4) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(5) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(6) (a) "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 benefits 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 benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code;

9. A public health plan, as defined in regulations; or

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)).

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (10) of this section;

(7) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(8) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, no employerorganized association shall be treated as an association, small group, or large group under this subtitle;

(9) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(10) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan;

(11) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(12) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals ***under KRS 304.17A-400 to 304.17A-480***;

(13) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program ***under KRS 304.17A-400 to 304.17A-480***;

(14) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(15) "Guaranteed acceptance program qualified individual" means an individual who***, on or before December 31, 2000***: (a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(16) "Guaranteed acceptance plan supporting insurer" means either an insurer***, on or before December 31, 2000,*** that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, ***on or before December 31, 2000,*** provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(17) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, 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, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(18) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Nurse practitioners licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(19) (a) "High-cost condition" ***pursuant to the Kentucky Guaranteed Acceptance Program,*** means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(20) “Index rate” means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(21) “Individual market” means the market for the health insurance coverage offered to individuals other than in connection with a group health plan;

(22) “Insurer” means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

(23) "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the

organization or day-to-day operation of the entity for the principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(24) “Large group” means:

(a) An employer with fifty-one (51) or more employees; or

(b) An affiliated group with fifty-one (51) or more eligible members;

(25) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(26) “Market segment” means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(27) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(28) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(29) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(30) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(31) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(32) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(33) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(34) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members; and

(35) "Standard benefit plan" means the plan identified in KRS 304.17A-250.

Section 18. KRS 304.17A-080 is amended to read as follows:

(1) There is hereby created and established a Health Insurance Advisory Council whose duties shall be to review and discuss with the commissioner any issues which impact the provision of health insurance in the state. The advisory council shall consist of ***nine (9)***~~[seven (7)]~~ members: the commissioner plus ***eight (8)***~~[six (6)]~~ persons appointed by the Governor with the advice of the commissioner to serve two (2) year terms. The commissioner shall serve as chair of the advisory council.

(2) The ***eight (8)***~~[six (6)]~~ persons appointed by the Governor with the advice of the commissioner shall be:

(a) Two (2) representatives of insurers currently offering health benefit plans in the state;

(b) Two (2) practicing health care providers;~~[and]~~

(c) Two (2) representatives of purchasers of health benefit plans***; and (d) Two (2) representatives of agents***.

(3) The council shall:

(a) Review and discuss the design of the standard health benefit plan;

(b) Review and discuss the rate-filing process for all health benefit plans;

(c) Review and discuss the administrative regulations concerning this subtitle to be promulgated by the department;

(d) Make recommendations on high-cost conditions as provided in subsection (5) of this section;~~[and]~~

(e) ***Advise the Department of Insurance concerning the Department of Insurance's separation plan for the division of duties and responsibilities between the operation of the Department of Insurance and the operation of Kentucky Access;***

(f) ***Review and discuss issues that impact Kentucky Access; and***

(g) Review and discuss other issues at the request of the commissioner.

(4) The advisory council shall be a budgetary unit of the department which shall pay all of the advisory council's necessary operating expenses and shall furnish all office space, personnel, equipment, supplies, and technical or administrative services required by the advisory council in the performance of the functions established in this section.

(5) ***Prior to January 1, 2001,*** no less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established by the commissioner under KRS 304.17A-005(19) and 304.17A-280 and recommend changes to the commissioner. The commissioner may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the commissioner deems appropriate. The council, in making recommendations, and the commissioner, in making changes, shall consider, among other things, actual claims and losses on each diagnosis and advances in treatment of high-cost conditions. ***On or after January 1, 2001, no less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established by the Department for Kentucky Access and report to the commissioner any and all recommended changes.***

(6) For each calendar year that the Kentucky Guaranteed Acceptance Program is operating, every insurer shall report to the commissioner and the Health Insurance Advisory Council, in the form and at the time as the commissioner by administrative regulation may specify, information that the commissioner deems necessary for the council and commissioner to evaluate the list of high-cost conditions as required under this section.

Section 19. KRS 304.17A-0952 is amended to read as follows:

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

(1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate***, except that the premium rates charged to an individual shall not vary from the index rate by more than fifty percent (50%) for two (2) consecutive years beginning January 1, 2001***.

(2) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed ***twenty***~~[ten]~~ percent ***(20%)***~~[(10%)]~~ annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business.

(3)~~[(a) Notwithstanding subsection (2) of this section, at renewal the insurer may replace modified community rates with rates determined in accordance with subsection (1) of this section.~~

~~(b) Within the limitations set out in subsections (1) and (2) of this section, the premium rate for health benefit plans issued to high-risk individuals under modified community rating who at the time of issue had a high-cost condition during the period from July 15, 1995, until April 10, 1998, for a new rating period:~~

~~1. Shall not be increased by more than twenty-five percent (25%) on either of thefirst two (2) renewal dates after April 10, 1998. The total increase shall not result in a rate that exceeds thirty-five percent (35%) of the index rate. Notwithstanding subsection (1) of this section, the program established under KRS 304.17A-400 shall reimburse the insurer for any premium loss incurred under this subsection to the extent that funds are available;~~

~~2. May be increased without restriction to the applicable rate as determined by theinsurer's rate manual on the third renewal date after April 10, 1998; and~~

~~3. Shall be subject to subsection (2) of this section on the fourth renewal date afterApril 10, 1998, and thereafter.~~

~~(4)~~ The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate**,** ***except that the premium rate charged to a small group or association shall not vary from the index rate by more than fifty percent (50%) for two (2) consecutive years beginning January 1, 2001***.

(4)[~~(5)~~] The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed ***twenty***[~~fifteen~~] percent ***(20%)***[~~(15%)~~] annually and adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business.

(5)[~~(6)~~] In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(6)[~~(7)~~] Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group.

(7)[~~(8)~~] The commissioner may approve establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the additional class would enhance the efficiency and fairness for the applicable market segment.

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).

(b) An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative cost related to the following reasons:

1. The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans; or

2. The insurer has acquired a class of business from another insurer.

~~(c)~~ ***Notwithstanding any other provision of this subsection, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected claims experience and administrative costs of the new class of business and the previous class of business.***

(8) ~~[(9)]~~ For the purpose of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs.

(9) ~~[(10)]~~ Notwithstanding any other provision of this section, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies.

(10) ~~[(11)]~~ Nothing in this section shall be construed to prevent an insurer from offering incentives to participate in a program of disease prevention or health improvement.

Section 20. KRS 304.17A-150 is amended to read as follows:

(1) On and after July 15, 1995, it is an unfair trade practice for an insurer, agent, broker, or any other person in the business of marketing and selling health plans, to commit or perform any of the following acts:

(a) Encourage individuals or groups to refrain from filing an application for coverage with the insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(b) Encourage or direct individuals or groups to seek coverage from another insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(c) Encourage an employer to exclude an employee from coverage.

The provisions of~~[paragraphs (a) and (b) of]~~ this subsection shall not apply to information provided regarding the established geographic service area of an insurer.

(2) It is an unfair trade practice for an insurer to compensate an agent, broker, or any other person in the business of marketing and selling health plans on the basis of the health status, claims experience, industry, occupation, or geographic location of the insured or prospective insured***, except as provided in Sections 1 to 16 of this Act***.

(3) It shall constitute an unfair trade practice for any insurer, insurance agent, or third-party administrator to refer an individual employee to ***Kentucky Access,*** ~~[the Kentucky guaranteed acceptance program]~~ or to arrange for an individual employee to apply to ***Kentucky Access*** ~~[that plan]~~, for the purpose of separating an employee from group health insurance coverage provided in connection with the individual's employment.

(4) ***It is an unfair trade practice for an insurer that offers multiple health benefit plans to require a health care provider, as a condition of participation in a health benefit plan of***

the insurer, to participate in any of the insurer's other health benefit plans. In addition to the proceedings and penalties provided in this chapter for violation of this provision, a contract violating this subsection is void.

(5) It is an unfair trade practice for an insurer not to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health-care provider from the insurer.

(6) ~~[(5)]~~ The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment

under ***Section 11 of this Act*** ~~[KRS 304.17A-470]~~. As an alternative, the commissioner may levy a civil penalty on any member insurer that fails to pay the assessment when due. The civil penalty shall not exceed five percent (5%) of the unpaid assessment per month, but no civil penalty shall be less than one hundred dollars ($100) per month.

(7) ~~[(6)]~~ The remedy provided by KRS 304.12-120 shall be available for conduct proscribed by this section.

Section 21. KRS 304.17A-250 is amended to read as follows:

(1) The commissioner shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan that shall provide health insurance coverage in the individual and small group markets after June 30, 1998. As a condition of doing business in the ~~[individual or]~~ small group market in the Commonwealth, the health insurer shall offer the standard health benefit plan, but the extent to which the standard health benefit plan shall be offered on a guaranteed issue basis shall only be as provided in KRS 304.17A-200 ~~[and 304.17A-210]~~. ***As a condition of doing business in the individual market on or after January 1, 2001, a health insurer shall offer the standard health benefit plan.*** Except as may be necessary to coordinate with changes in federal law, the commissioner shall not alter, amend, or replace the standard health benefit plan more frequently than annually. Initially, the standard health benefit plan shall be the standard high plan in effect on April 10, 1998.

(2) The standard health benefit plan shall be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of ***Section 11 of this Act*** ~~[KRS 304.17A-430]~~ for inclusion in calculating assessments and refunds under ***Kentucky Access*** ~~[the guaranteed acceptance program]~~.

(4) Any health insurer who elects to offer health insurance policies in the individual or small group markets in this state shall, as a condition of offering health benefit plans in this state after June 30, 1998, offer and issue the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are more generous to the applicant than the health insurer would be required to provide under KRS 304.17A200,~~[304.17A-210,]~~ 304.17A-220, 304.17A.230, and 304.17A-240.

(6) Insurance agents licensed under this chapter who present for sale any health benefit plan in the individual or small group markets to a prospective applicant shall also inform that person of the existence of the standard benefit plan in the same form of coverages offered by the same insurer.

(7) (a) A benefits comparison shall be delivered to a prospective applicant for any health insurance coverage in the individual or small group markets at the time of initial solicitation through means that prominently direct the attention of the prospective applicant to the document and its purpose.

1. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of a benefits comparison.

2. In the case of agent solicitations, an agent shall deliver the benefits comparison to the prospective applicant prior to the presentation of an application or enrollment form.

3. In the case of direct response solicitations, the benefits comparison shall be presented in conjunction with any application or enrollment form.

(b) The benefits comparison given to a prospective applicant shall include:

1. A description of the principal benefits and coverage provided in the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant;

2. A statement of the principal exclusions, reductions, and limitations contained in the standard health benefit plan offered under this section, and the health benefit plan being offered to the prospective applicant; and

3. A chart providing a direct comparison of the insurer's premium rate for the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant.

(c) At the time of the execution of an application for any health benefit plan, the prospective applicant shall sign a statement contained in or accompanying the application, which shall remain on file with the health insurer for five (5) years, indicating that the insured has been provided with and understands the benefits comparison required by this subsection.

(d) As used in this subsection and in subsection (6) of this section, the term "prospective applicant" refers only to a natural person who is a resident of the Commonwealth and who is purchasing health insurance coverage in the individual market providing benefits to that person, that person's spouse, or that person's children. It does not include an employer or representative of an employer who is considering health insurance coverage that would provide benefits to employees and their families.

(8) All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(9) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the commissioner as provided in KRS 304.18-085.

(10) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(11) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(12) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a ***properly*** completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an ***applicant or*** insured with a ***disclosed*** high-cost condition ***as specified in Section 1 of this Act or for any reason,*** shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the~~[specific high-cost condition that is the]~~ basis for refusing to issue a policy, a description of ***Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access***~~[the Guaranteed Acceptance Program, and the name and the telephone number of a contact person who can provide additional information about the Guaranteed Acceptance Program]~~.

(13) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(14) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

Section 22. KRS 304.17A-260 is amended to read as follows:

An insurer that, on or after July 15, 1995, until April 10, 1998, issued standard health benefit plans under KRS 304.17A-160 and then ceased doing business in Kentucky may apply to the commissioner on or after ***the effective date of this Act*** ~~[April 10, 1998]~~, until ***April*** ~~[January]~~ 1, ***2001*** ~~[1999]~~, for approval to reenter Kentucky, and if the commissioner grants approval the insurer may engage in the health insurance business notwithstanding the provisions of KRS 304.17A110(1)(d) as it existed on the date the insurer ceased doing business in Kentucky.

Section 23. KRS 304.17A-320 is amended to read as follows:

(1) No employer-organized association shall in this state self-insure in order to provide health benefit plans for its members unless it holds a certificate of filing from the commissioner.

(2) To qualify for a certificate of filing and to maintain a certificate of filing, the employerorganized association shall comply with the provisions of Subtitle 48 of this chapter to the extent not in conflict with the expressed provisions of this section.

(3) Each association that holds a certificate of filing from the commissioner shall be subject to the following:

(a) All assessments placed on insurers under ***Section 11 of this Act*** ~~[KRS 304.17A-460]~~;

(b) All rating restrictions placed on employer-organized associations under KRS 304.17A0954;

(c) All rate review requirements placed on insurers under this subtitle; (d) All data collection requirements placed on insurers under this subtitle; and (e) Provisions of Subtitle 12 of this chapter that apply to health insurers.

(4) Each association that holds a certificate of filing from the commissioner shall notify its members that health benefit plans issued to its members through the association are not protected through the Kentucky Life and Health Insurance Guaranty Association.

(5) Under the provisions of KRS 304.48-220, the commissioner may revoke the certificate of filing of any association. A violation of any provision of this section shall be deemed a violation of Subtitle 48 of this chapter for purposes of KRS 304.48-220.

SECTION 24. A NEW SECTION OF KRS 304.17A-500 TO 304.17A-570 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "hospitalist" means a physician of record at a hospital for a patient of a participating physician and who may return the care of the patient to that physician at the end of the hospitalization.

(2) A contract between a managed care plan and a physician shall not require the mandatory use of a hospitalist.

Section 25. KRS 304.17A-095 is amended to read as follows:

(1) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers, shall submit a copy of the filing to the Attorney General, and shall comply with the provisions of this section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the commissioner. The insurer may submit new filings from time to time as it deems proper.

(2) (a) A rate filing under this section may be used by the insurer on and after the date of filing with the commissioner prior to approval by the commissioner. A rate filing shall be approved or disapproved by the commissioner within sixty (60) days after the date of filing. Should sixty (60) days expire after the commissioner receives the filing before approval or disapproval of the filing, the filing shall be deemed approved. The commissioner may hold a hearing within sixty (60) days after receiving a filing

containing a rate increase. Not less than thirty (30) days in advance of a hearing held under this section, the commissioner shall notify the Attorney General in writing of the hearing. The Attorney General may participate as a health insurance consumer intervenor and be considered a party to the hearing.

(b) The commissioner shall hold a hearing upon written request, including the reasons for the request, by the Attorney General, provided the request is in accordance with subsection (3) of this section.

(c) The commissioner shall hold a hearing, unless waived by the health insurer, before ordering a retroactive reduction of rates.

(d) The hearing shall be a public hearing conducted in accordance with KRS Chapter 13B.

(e) In the circumstances of a filing that has been deemed approved under paragraph (a) of this subsection, the commissioner shall have the authority to order a retroactive reduction of rates to a reasonable rate if after applying the factors in subsection (3) of this section the commissioner determines that the rates were unreasonable. If the commissioner seeks to order a retroactive reduction of rates and more than one (1) year has passed since the date of the filing, the commissioner shall consider the reasonableness of the rate over the entire period during which the filing has been in effect.

(3) In approving or disapproving a filing under this section, the commissioner shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium or fee charged;

(b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;

(c) Previous premium rates or fees for the policies or contracts to which the filing applies;

(d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;

(e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory; and

(f) The effect on the rates of any assessment made under ***Section 11 of this Act***~~[KRS 304.17A-460]~~; and

(g) Other factors as deemed relevant by the commissioner.

(4) The rates for each policyholder shall be guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.

(5) At any time the commissioner, after a public hearing for which at least thirty (30) days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and

subscribers if the commissioner determines that the rates or fees previously approved are in violation of this chapter.

(6) ***Notwithstanding subsection (2)(a) to (e) of this section, premium rates may be used upon filing with the department of a policy form not previously used if the filing is accompanied by the policy form filing and a minimum loss ratio guarantee. Insurers may use the filing procedure specified in this subsection only if the affected policy forms disclose the benefit of a minimum loss ratio guarantee. An insurer may not elect to use***

the filing procedure in this subsection for a policy form that does not contain the minimum loss ratio guarantee. Insurers may not amend policy forms to provide for a minimum loss ratio guarantee. If an insurer elects to use the filing procedure in this subsection for a policy form or forms, the insurer shall not use a filing of premium rates that does not provide a minimum loss ratio guarantee for that policy form or forms. (a) The minimum loss ratio shall be in writing and shall contain at least the following:

1. An actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subsection;

2. A statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;

3. Detailed experience information concerning the policy forms;

4. A step-by-step description of the process used to develop the experience loss ratio, including demonstration with supporting data;

5. A guarantee of a specific lifetime minimum loss ratio, that shall be greater than or equal to the following, taking into consideration adjustments for duration as set forth in administrative regulations promulgated by the commissioner:

a. Seventy percent (70%) for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers;

b. Seventy percent (70%) for policies issued to small groups of two (2) to ten (10) employees or for certificates issued to members of an association that offers coverage to small employers; and

c. Seventy-five percent (75%) for policies issued to small groups of eleven (11) to fifty (50) employees;

6. A guarantee that the actual Kentucky loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph, adjusted for duration;

7. A guarantee that the actual Kentucky lifetime loss ratio shall meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph; and

8. If the annual earned premium volume in Kentucky under the particular policy form is less than two million five hundred thousand dollars ($2,500,000), the minimum loss ratio guarantee shall be based partially on the Kentucky earned premium and other credibility factors as specified by the commissioner.

(b) The actual Kentucky minimum loss ratio results for each year at issue shall be independently audited at the insurer's expense and the audit shall be filed with the commissioner not later than one hundred twenty (120) days after the end of the year at issue. The audit shall demonstrate the calculation of the actual Kentucky loss ratio in a manner prescribed as set forth in administrative regulations promulgated by the commissioner.

(c) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio.

(d) A Kentucky policyholder affected by the guaranteed minimum loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund shall be made to all Kentucky policyholders insured under the applicable policy form during the year at issue if the refund would equal ten dollars ($10) or more per policy. The refund shall include statutory interest from July 1 of the year at issue until the date of payment. Payment shall be made not later than one hundred eighty (180) days after the end of the year at issue.

(e) Premium refunds of less than ten dollars ($10) per insured shall be aggregated by the insurer and paid to the Kentucky State Treasury.

(f) None of the provisions of subsections (2) and (3) of this section shall apply if premium rates are filed with the department and accompanied by a minimum loss ratio guarantee that meets the requirements of this subsection. Such filings shall be deemed approved. Each insurer paying a risk assessment under ***Section 11 of this Act***~~[KRS 304.17A-460]~~ may include the amount of the assessment in establishing premium rates filed with the commissioner under this section. The insurer shall identify any assessment allocated.

(g) The policy form filing of an insurer using the filing procedure with a minimum loss ratio guarantee will disclose to the enrollee, member, or subscriber as prescribed by the commissioner an explanation of the lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(h) The insurer who elects to use the filing procedure with a minimum loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than ten dollars ($10).

(7) The commissioner may by administrative regulation prescribe any additional information related to rates, fees, dues, and other charges as they relate to the factors set out in subsection (3) of this section that he or she deems necessary and relevant to be included in the filings and the form of the filings required by this section. ***When determining a loss ratio for the purposes of loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local premium taxes less other assessments. For purposes of determining the loss ratio for any loss ratio guarantee pursuant to this section, the commissioner may examine the insurer's expenses for preferred provider organization, case management, utilization review, and reinsurance used by the insurer in calculating the loss ratio***

guarantee for reasonableness. Only those expenses found to be reasonable by the commissioner may be used by the insurer for determining the loss ratio for purposes of any loss ratio guarantee.

Section 26. KRS 304.17A-290 is amended to read as follows:

(1) Coverage of an individual who is not a state employee or a small group which on April 10, 1998, is covered under KRS 18A.2251 or KRS 18A.2281 shall not be renewed after April 10, 1998.

(2) The state employee health insurance fund established under KRS 18A.2281 shall be deemed an insurer as defined in KRS 304.17A-005 only for the coverage it provides to individuals not state employees or to small groups and only until such time as this coverage terminates in accordance with subsection (1) of this section.

(3)~~[The state employee health insurance fund established under KRS 18A.2281 shall be subject to assessments and reimbursements under KRS 304.17A-400 to 304.17A-480 only for the premium collected and the claims paid for individuals who are not state employees and the small groups which are covered by the fund.~~

~~(4)]~~ Except as provided in this section, the state employee health insurance fund established under KRS 18A.2281 shall not be deemed an insurer for any other purpose in this chapter and, in no event, at any time more than twelve (12) months after April 10, 1998, shall it be deemed to be an insurer.

Section 27. KRS 304.17A-0954 is amended to read as follows:

(1) For purposes of this section:

(a) "Base premium rate" has the meaning provided in KRS 304.17A-005;

(b) "Employer" means a person engaged in a trade or business who has two (2) or more employees within the state in each of twenty (20) or more calendar weeks in the current or preceding calendar year;

(c) "Employer-organized association" means any of the following:

1. Any entity which was qualified by the commissioner as an eligible association prior to April 10, 1998, and which has actively marketed a health insurance program to its members after September 8, 1996, and which is not insurercontrolled;

2. An entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and which is not insurer-controlled; or

3. Any entity which is a bona fide association as defined in 42 U.S.C. sec. 300gg91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation; (d) "Index rate" has the meaning provided in KRS 304.17A-005.

(2) Notwithstanding any other provision of this chapter, the amount or rate of premiums for an employer-organized association health plan may be determined, subject to the restrictions of subsection (3) of this section, based upon the experience or projected experience of the employer-organized associations whose employers obtain group coverage under the plan. Without the written consent of the employer-organized association filed with the commissioner, the index rate for the employer-organized association shall be calculated solely with respect to that employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.

(3) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized health insurance plan:

(a) The premium rates charged during a rating period to members of the employerorganized association with similar characteristics for the same or similar coverage, or the premium rates that could be charged to a member of the employer-organized association under the rating system for that class of business, shall not vary from its own index rate by more than twenty-five percent (25%) of its own index rate***, except that the premium rates charged to an employer-organized association shall not vary from the index rate by more than fifty percent (50%) for two (2) consecutive years beginning January 1, 2001***.

(b) The percentage increase in the premium rate charged to an employer member of an employer-organized association for a new rating period shall not exceed the sum of the following:

1. The percentage change in the new business premium rate for the employerorganized association measured from the first day of the prior rating period to the first day of the new rating period;

2. Any adjustment, not to exceed ***twenty***~~[fifteen]~~ percent ***(20%)***~~[(15%)]~~ annually and adjusted pro rata for rating period of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the member as determined from the insurer's rate manual; and

3. Any adjustment due to change in coverage or change in the case characteristics of the member as determined by the insurer's rate manual.

(4) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(5) For the purpose of this section, a health insurance contract that utilizes a restricted provider network shall not be considered similar coverage to a health insurance contract that does not utilize a restricted provider network if utilization of the restricted provider network results in measurable differences in claims costs.

Section 28. KRS 304.32-270 is amended to read as follows:

Nonprofit hospital, medical-surgical, dental, and health service corporations shall be subject to the provisions of this subtitle, and to the following provisions of this code, to the extent applicable and not in conflict with the express provisions of this subtitle: (1) Subtitle 1 -- Scope -- General Definitions and Provisions;

(2) Subtitle 2 -- Insurance Commissioner;

(3) Subtitle 7 -- Investments;

(4) Subtitle 8 -- Administration of Deposits;

(5) Subtitle 12 -- Trade Practices and Frauds;

(6) Subtitle 25 -- Continuity of Management;

(7) Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(8) Subtitle 18 -- KRS 304.18-110, 304.18-120 -- Group Conversion and KRS 304.18-045;

(9) Subtitle 4 -- Fees and Taxes;

(10) Subtitle 99 -- Penalties;

(11) Subtitle 14 -- KRS 304.14-500 to 304.14-560;~~[and]~~

(12) Subtitle 17A -- Health Benefit Plans***; and***

(13) ***Subtitle 17B --Kentucky Access***.

Section 29. KRS 304.38-200 is amended to read as follows:

Health maintenance organizations shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(1) Subtitle 1 -- Scope -- General Definitions and Provisions;

(2) Subtitle 2 -- Insurance Commissioner;

(3) Subtitle 3 -- Authorization of Insurers and General Requirements;

(4) Subtitle 4 -- Fees and Taxes;

(5) Subtitle 5 -- Kinds of Insurance -- Limits of Risk -- Reinsurance;

(6) Subtitle 6 -- Assets and Liabilities;

(7) Subtitle 7 -- Investments;

(8) Subtitle 8 -- Administration of Deposits;

(9) Subtitle 12 -- Trade Practices and Frauds;

(10) Subtitle 14 -- KRS 304.14-500 to 304.14-560;

(11) Subtitle 17A -- Health Benefit Plans;

(12) ***Subtitle 17B -- Kentucky Access;***

(13) Subtitle 25 -- Continuity of Management;

(14)~~[(13)]~~ Subtitle 33 -- Insurers Rehabilitation and Liquidation; ***(15)***~~[(14)]~~

Subtitle 37 -- Insurance Holding Company Systems; and

(16)~~[(15)]~~ Subtitle 99 -- Penalties.

Section 30. KRS 91A.080 is amended to read as follows:

(1) The legislative body of each city, county, or urban-county government which elects to impose and collect license fees or taxes upon insurance companies for the privilege of engaging in

the business of insurance may enact or change its license fee or rate of tax to be effective July 1 of each year on a prospective basis only and shall file with the commissioner of insurance at least one hundred (100) days prior to the effective date, a copy of all ordinances and amendments which impose any such license fee or tax. No less than eightyfive (85) days prior to the effective date, the commissioner of insurance shall promptly notify each insurance company engaged in the business of insurance in the Commonwealth of those cities, county, or urban-county governments which have elected to impose the license fees or taxes and the current amount of the license fee or rate of tax.

(2) Any license fee or tax imposed by a city, county, or urban-county government upon an insurance company with respect to life insurance policies, may be based upon the first year's premiums, and if so based, shall be applied to the amount of the premiums actually collected within each calendar quarter upon the lives of persons residing within the corporate limits of the city, county, or urban-county government.

(3) Any license fee or tax imposed by a city, county, or urban-county government upon any insurance company with respect to any policy which is not a life insurance policy shall be based upon the premiums actually collected by the company within each calendar quarter on risks located within the corporate limits of the city, county, or urban-county government on those classes of business which the company is authorized to transact, less all premiums returned to policyholders. In determining the amount of license fee or tax to be collected and to be paid to the city, county, or urban-county government, the insurance company shall use the tax rate effective on the first day of the policy term. When an insurance company collects a premium as a result of a change in the policy during the policy term, the tax rate used shall be the rate in effect on the effective date of the policy change. With respect to premiums returned to policyholders, the license fee or tax shall be returned by the insurance company to the policyholder pro rata on the unexpired amount of the premium at the same rate at which it was collected and shall be taken as a credit by the insurance company on its next quarterly report to the city, county, or urban-county government. Any license fee or tax imposed upon premium receipts shall not include premiums received for insuring employers against liability for personal injuries to their employees, or the death of their employees, caused thereby, under the provisions of the Workers' Compensation Act.

(4) The Department of Insurance shall, by administrative regulation, provide for a reasonable collection fee to be retained by the insurance company or its agent as compensation for collecting the tax, except that the collection fee shall not be more than fifteen percent (15%) of the fee or tax collected and remitted to the city, county or urban-county government or two percent (2%) of the premiums subject to the tax, whichever is less. To facilitate computation, collection, and remittance of the fee or tax and collection fee provided in this section, the fees or taxes set out in subsection (1), (2), or (3) of this section, together with the collection fee in this section, may be rounded off to the nearest dollar amount.

(5) Pursuant to KRS 304.3-270, if any other state retaliates against any Kentucky domiciliary insurer because of the requirements of this section, the commissioner of insurance shall impose an equal tax upon the premiums written in this state by insurers domiciled in the other state.

(6) Accounting and reporting procedures for collection and reporting of the fees or taxes and the collection fee herein provided shall be determined by administrative regulations promulgated by the Department of Insurance.

(7) Upon written request of the legislative body of any city, county, or urban-county government, at the expense of the requesting city, county, or urban-county government, which shall be paid in advance by the city, county, or urban-county government to the Department of Insurance, the Department of Insurance shall examine, or cause to be examined by contract with qualified auditors, the books or records of the insurance companies or agents subject to the fee or tax to determine whether the fee or tax is being properly collected and remitted, and the findings of the examination shall be reported to the city, county, or urban-county government. Willful failure to properly collect and remit the fee or tax imposed by a city, county, or urban-county government pursuant to the authority granted by this section shall constitute grounds for the revocation of the license issued to an insurance company or agent under the provisions of KRS Chapter 304.

(8) The license fees or taxes provided for by subsections (2) and (3) of this section shall be due thirty (30) days after the end of each calendar quarter. Annually, by March 31, each insurer shall furnish each city, county, or urban-county government, to which the tax or fee is remitted, with a breakdown of all collections in the preceding calendar year for the following categories of insurance:

(a) Casualty;

(b) Automobile;

(c) Inland marine;

(d) Fire and allied perils;

(e) Health; and (f) Life.

(9) Any license fee or tax not paid on or before the due date shall bear interest at the tax interest rate as defined in KRS 131.010(6) from the date due until paid. Such interest payable to the city, county, or urban-county government is separate of penalties provided for in subsection (7) of this section. No city, county, or urban-county government may impose any penalties other than those provided for in this subsection.

(10) No license fee or tax imposed under this section shall apply to premiums received on policies of group health insurance provided for state employees under KRS 18A.225 and KRS 42.800 to 42.825.

(11) No county may impose the tax authorized by this section upon the premiums received on policies issued to public service companies which pay ad valorem taxes.

(12) Insurance companies which pay license fees or taxes pursuant to this section shall credit city license fees or taxes against the same license fees or taxes levied by the county, when the license fees or taxes are levied by the county on or after July 13, 1990.

(13) ***No license fee or tax imposed under this section shall apply to premiums received on health insurance policies issued to individuals nor to policies issued through Kentucky Access created in Section 3 of this Act.***

Section 31. KRS 304.17A-515 is amended to read as follows:

(1) A managed care plan shall arrange for a sufficient number and type of primary care providers and specialists throughout the plan's service area to meet the needs of enrollees. Each managed care plan shall demonstrate that it offers:

(a) An adequate number of accessible acute care hospital services, where available;

(b) An adequate number of accessible primary care providers, including family practice and general practice physicians, internists, obstetricians/gynecologists, and pediatricians, where available;

(c) An adequate number of accessible specialists and subspecialists, and when the specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to nonparticipating health care providers with prior plan approval;

(d) The availability of specialty services; and

(e) ***A provider network that meets the following accessibility requirements:***

1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or

2. For areas other than urban areas, a provider network that makes available primary care physician services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available~~[A provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence, to the extent those services are available]~~.

(2) A managed care plan shall provide telephone access to the plan during business hours to ensure plan approval of nonemergency care. A managed care plan shall provide adequate information to enrollees regarding access to urgent and emergency care.

(3) A managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care.

Section 32. The following KRS sections are repealed effective January 1, 2001:

304.17A-210 Guaranteed-issue basis of individual market plans -- Guidelines -- Exceptions.

304.17A-280 Additions to high-cost conditions list -- Hearing.

304.17A-400 Guaranteed Acceptance Program -- Nondiscrimination in provider payment - Participation by insurer as condition to do business.

304.17A-420 Participating insurer -- Written notification of program status -- Program participating insurer requirements -- Exemptions.

304.17A-440 Premium -- Limitations.

304.17A-460 Insurer annual reports -- Department calculations and notification to insurer - Assessments and refunds -- Stop-loss carrier -- Examinations of participating insurers.

304.17A-470 Risk adjustment process -- Program account -- Funding -- Calculation of losses - Assessments.

304.17A-480 Report to Legislative Research Commission -- Audit.

Section 33. Sections 19, 20, 21, 23, 25, 26, and 27 of this Act take effect January 1, 2001.

Approved April 21, 2000