CHAPTER 105

(SB 146)

AN ACT relating to health insurance.

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

Section 1. KRS 304.17A-605 is amended to read as follows:

(1) KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A.-609, 304.17A-611, 304.17A-613, and 304.17A-615 set forth the requirements and procedures regarding utilization review and shall apply to:

(a) Any insurer or its private review agent that provides or performs utilization review in connection with a health benefit plan ***or a limited health service benefit plan***; and

(b) Any private review agent that performs utilization review functions on behalf of any person providing or administering health benefit plans ***or limited health service benefit plans***.

(2) Where an insurer or its agent provides or performs utilization review, and in all instances where internal appeals as set forth in KRS 304.17A-617, are involved, the insurer or its agent shall be responsible for:

(a) Monitoring all utilization reviews and internal appeals carried out by or on behalf of the insurer;

(b) Ensuring that all requirements of KRS 304.17A-600 to 304.17A-633 are met;

(c) Ensuring that all administrative regulations promulgated in accordance with KRS 304.17A-609, 304.17A-613, and 304.17A-629 are complied with; and

(d) Ensuring that appropriate personnel have operational responsibility for the performance of the insurer's utilization review plan.

(3) A private review agent that operates solely under contract with the federal government for utilization review or patients eligible for hospital services under Title XVIII of the Social Security Act shall not be subject to the registration requirements set forth in KRS 304.17A-607, 304.17A-609, and 304.17A-613.

SECTION 2. SUBTITLE 17C 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) "At the time of enrollment" means the same as defined in KRS 304.17A-005(2);

(2) "Enrollee" means an individual who is enrolled in a limited health service benefit plan;

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005(19);

(4) "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, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

(5) "Limited health service benefit plan" means any policy or certificate that provides services for dental, vision, mental health, substance abuse, chiropractic, pharmaceutical, podiatric, or other such services as may be determined by the commissioner to be offered under a limited health service benefit plan. A limited health service benefit plan shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the plan.

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

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the limited health benefit plan and who is willing to meet the terms and conditions for participation established by the insurer.

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

(1) An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its limited health service benefit plan and shall promptly provide the covered person and enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(2) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review; and

2. An internal appeal of a utilization review decision made by or on behalf of the insurer with respect to the denial, reduction, or termination of a limited health service benefit plan or the denial of payment for a health care service, and the procedure to initiate an internal appeal;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the commissioner shall require by administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary, and, upon request of an insured or enrollee, a complete drug formulary; and

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer.

(3) The insurer shall file the information required under this section with the department.

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

An insurer that offers a limited health service benefit plan that utilizes a provider network shall have a provider network that is available to all persons enrolled in the plan within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent available.

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

(1) Insurers shall establish relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider in the plan. Standards shall be reasonably related to services provided. Selection or participation standards based on the economics or capacity of a provider's practice shall be adjusted to account for case mix, severity of illness, patient age, and other features that may account for higher than expected or lower than expected costs. All data profiling or other data analysis pertaining to participating providers shall be done in a manner which is valid and reasonable. Plans shall not use criteria that would allow an insurer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health services utilization, or that would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health services utilization.

(2) Each insurer shall establish mechanisms for soliciting and acting upon applications for provider participation in the plan in a fair and systematic manner. These mechanisms shall, at a minimum, include:

(a) Allowing all providers who desire to apply for participation in the plan an opportunity to apply at any time during the year, or, where an insurer does not conduct open continuous provider enrollment, conducting a provider enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of the enrollment period; and

(b) Making criteria for provider participation in the plan available to all applicants.

(3) An insurer that offers a limited health service benefit plan shall establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board.

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

(1) An insurer shall file with the commissioner sample copies of any agreements it enters into with providers for the provision of health care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due to providers by the insurer;

2. Insolvency of the insurer; or

3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

(b) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the insurer; and

(c) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide health care services to the subscriber, dependent of the subscriber, or enrollee of a limited health service benefit plan, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) An insurer that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including, but not limited to, the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with the requirements of this subtitle in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The commissioner shall have access to a specific risk-sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the department shall be considered to be a trade secret and shall not be subject tot KRS 61.872 to 61.884.

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

(1) An insurer may not contract with a health care provider to limit the provider's disclosure to an enrollee, or to another person on behalf of an enrollee, of any information relating to the enrollee's medical condition or treatment option.

(2) A health care provider shall not be penalized, or a health care provider's contract with a limited health service benefit plan terminated, because the provider discusses medically necessary or appropriate care with an enrollee or another person on behalf of an enrollee.

(a) The health care provider may not be prohibited by the plan from discussing all treatment options with the enrollee.

(b) Other information determined by the health care provider to be in the best interests of the enrollee may be disclosed by the provider to the enrollee or to another person on behalf of an enrollee.

(3) (a) A health care provider shall not be penalized for discussing financial incentives and financial arrangements between the provider and the insurer with an enrollee.

(b) Upon request, an insurer shall inform its enrollees in writing of the type of financial arrangements between the plan and participating providers if those arrangements include an incentive or bonus.

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

(1) Each insurer shall have a process for the selection of health care providers who will be on the plan's list of participating providers, with written policies and procedures for review and approval used by the plan.

(2) The plan shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state.

(3) The plan shall demonstrate that it has consulted with appropriately qualified health care providers to establish the minimum professional requirements.

(4) The plan's selection process shall include verification of each health care provider's license, history of license suspension or revocation, and liability claims history.

(5) An insurer shall establish a formal written, ongoing process for the reevaluation of each participating health care provider within a specified number of years after the provider's initial acceptance into the plan. The reevaluation shall include an update of the previous review criteria and an assessment of the provider's performance pattern based on criteria such as enrollee clinical outcomes, number of complaints, and malpractice actions.

SECTION 10. SUBTITLE 38A 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) "Enrollee" means an individual who is enrolled in a limited health services benefit plan;

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a a limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in Section 2 of this Act unless exempted by the commissioner;

(3) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, chiropractic services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the limited health services set forth in this subsection;

(4) "Limited health service contract" means any contract entered into by a limited health service organization with a policyholder to provide limited health services;

(5) "Limited health service organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange limited health service or services to enrollees. A limited health service organization does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited health service organization, health maintenance organization, or a health insurer; and

(6) "Provider" means the same as defined in KRS 304.17A-005(19).

SECTION 11. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

No person may operate a limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this section and Sections 12, 13, 14, 15, 16, 18, and 20 of this Act, except an insurer authorized to transact health insurance in this state.

SECTION 12. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

An application for a certificate of authority to operate a limited health service organization shall be filed with the commissioner on a form prescribed by the commissioner. The application shall be verified by an officer or authorized representative of the applicant and shall set forth, or be accompanied by, the following:

(1) A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to these documents;

(2) A copy of all bylaws, rules, and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs;

(3) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent (10%) or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association. Such listing shall fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the limited health service organization, including any possible conflicts of interest;

(4) A complete biographical statement, on forms prescribed by the department, with respect to each individual identified under this section;

(5) A statement generally describing the applicant, its facilities, personnel, and the limited health services to be offered;

(6) A copy of the form of any contract made, or to be made between the applicant and any person listed in subsection (3) of this section;

(7) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions including, but not limited to, marketing, administration, enrollment, investment management and provider agreements, subcontract agreements, and risk-sharing arrangements for the provision of limited health services to enrollees;

(8) A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which shall be consolidated financial statements of the applicant, shall satisfy this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this subtitle;

(9) A copy of the applicant's financial plan, including a three (3) year projection of anticipated operating results with all material assumptions, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies;

(10) A description of the proposed method of marketing;

(11) A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served in accordance with KRS 304.3-230;

(12) A description of how the applicant will comply with Sections 13 and 17 of this Act;

(13) The fee for issuance of a certificate of authority provided in Subtitle 4 of this chapter; and

(14) Such other information as the commissioner may reasonably require to make the determinations required by this subtitle.

SECTION 13. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Following receipt of an application filed pursuant to Section 12 of this Act, the commissioner shall review the application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant if the following conditions are met:

(a) The applicant has verified to the commissioner that it has an initial minimum worth of at least two hundred fifty thousand dollars ($250,000);

(b) The requirements of Section 12 of this Act have been fulfilled;

(c) The individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education;

(d) The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making his determination, the commissioner may consider:

1. The financial soundness;

2. The adequacy of surplus, working capital, other sources of funding, and provisions for contingencies;

3. Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the limited health service organization; and

4. The manner in which the requirements of Section 12 of this Act have been fulfilled; and

(e) Any deficiencies identified by the commissioner have been corrected.

(2) If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The limited health service organization shall have sixty (60) days from the date of receipt of the notice to request a hearing before the commissioner pursuant to KRS 304.2-310.

(3) Each certificate of authority issued to a limited health service organization shall designate the type of services the limited health service organization is authorized to provide.

SECTION 14. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

In order to maintain its eligibility for a certificate of authority, a limited health service organization shall continue to meet all conditions required to be met under this subtitle and the relevant administrative regulations for the initial application for and issuance of its certificate of authority under this subtitle.

SECTION 15. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) A limited health service organization may add one (1) or more limited health services by :

(a) Filing the relevant information required by Section 12 of this Act;

(b) Demonstrating compliance with Sections 12 and 17 of this Act; and

(c) Obtaining approval from the commissioner prior to offering the additional limited health service.

(2) If the filings are disapproved, the commissioner shall notify the limited health service organization and shall specify the reasons for disapproval in the notice. The limited health service organization shall have sixty (60) days from the date of receipt of the notice to request a hearing before the commissioner pursuant to KRS 304.2-310.

SECTION 16. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

A limited health service organization 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 9--Agents, Consultants, Solicitors, and Adjusters;

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

(11) Subtitle 14--The Insurance Contract;

(12) Subtitle 17--Health Insurance Contracts;

(13) Subtitle 17C--Limited Health Services Benefit Plans;

(14) Subtitle 18--Group and Blanket Health Insurance;

(15) Subtitle 24--Domestic Stock and Mutual Insurers;

(16) Subtitle 25--Continuity of Management;

(17) Subtitle 26--Insider Trading of Equity Securities;

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

(19) Subtitle 37--Insurance Holding Company Systems;

(20) Subtitle 47--Insurance Fraud; and

(21) Subtitle 99--Penalties.

SECTION 17. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Each limited health service organization shall at all times have and maintain a net worth of not less than one hundred twenty-five thousand dollars ($125,000).

(2) (a) Each limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner in an amount equal to fifty thousand dollars ($50,000).

(b) The deposit shall be an admitted asset.

(3) A limited health service organization shall at all times comply with the risk-based capital requirements for health organizations in administrative regulations promulgated by the commissioner for health maintenance organizations and other health organizations.

SECTION 18. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The commissioner may suspend or revoke the certificate of authority issued to a limited health service organization pursuant to this subtitle upon determining that any of the following conditions exist;

(a) The limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to Section 12 of this Act, unless amendments to the submissions have been filed with and approved by the commissioner;

(b) The limited health service organization issues an evidence of coverage or schedule of charges for limited health services which does not comply with the requirements of Subtitle 17C of this chapter;

(c) The limited health service organization is unable to fulfill its obligations to furnish limited health services;

(d) The limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(e) The net worth of the limited health service organization is less than that required by Section 17 of this Act or the limited health service organization has failed to correct any deficiency in its net worth as required by the commissioner;

(f) The continued operation of the limited health service organization would be hazardous to its enrollees; or

(g) The limited health service organization has otherwise failed to comply with this subtitle.

(2) If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he or she shall notify the limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty (60) days thereafter for a hearing on the matter in accordance with KRS Chapter 13B.

(3) When the certificate of authority of a limited health service organization is revoked, the organization shall proceed, immediately following the effective date of the order of

revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

(4) A limited health service organization shall be subject to the provisions of KRS 304.2-210 to 304.2-300 and to the provisions of Subtitle 2 of this chapter for determining financial condition, market conduct, and business practices.

SECTION 19. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Any limited health service organization that contracts with a provider or provider organization for the transfer of risk to the provider shall take reasonable steps to ensure the transferee is able to accept and manage the risk to be transferred. The limited health service organization shall submit a plan for evaluating a provider's or provider organization's ability to accept and manage risk to the department for approval at least forty-five (45) days prior to the proposed date of the transfer of any risk.

(2) If a limited health service organization transfers risk to a provider:

(a) Not in compliance with the standards listed in its approved plan; or

(b) Prior to filing or receiving approval of its plan,

the commissioner may require the limited health service organization to retain additional reserves to cover the risk transferred.

SECTION 20. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) A person issued a single service organization certificate of authority in accordance with KRS 304.38-065 and holding the certificate of authority on the effective date of this Act shall be converted to a limited health service organization as defined in Section 10 of this Act. At the next renewal of the certificate of authority, the person shall be issued a certificate of authority to act as a limited health service organization if it meets the requirements for continuance of the certificate of authority. No certificate of authority to act as a single service organization shall be issued or renewed after the effective date of this Act.

(2) A single service organization holding a certificate of authority immediately prior to the effective date of this Act, that is converted to a limited health service organization according to subsection (1) of this section shall continue to be required to meet the minimum net worth requirement of one hundred twenty-five thousand dollars ($125,000), and shall comply with the risk-based capital requirements for health organizations in administrative regulations promulgated by the commissioner for health maintenance organizations and other health organizations.

Section 21. KRS 304.33-430 is amended to read as follows:

The order of distribution of claims from the insurer's estate shall be as stated in this section. The first fifty dollars ($50) of the amount allowed on each claim in the classes under subsections (3) to (7), inclusive, of this section, shall be deducted from the claim and included in the class under

subsection (9) of this section. Claims may not be cumulated by assignment to avoid application of the fifty dollars ($50) deductible provision. Subject to the fifty dollars ($50) deductible provision, every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder, or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies.

(1) Administration costs. The costs and expenses of administration, including but not limited to the following: the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney's fees.

(2) Health maintenance organization ***and limited health service organization*** out-of-network claims. In a liquidation of a health maintenance organization ***or limited health service organization***, any claims for health plan benefits ***or for limited health service contract benefits*** for out-of-network claims that would have otherwise been covered.

(3) Loss and unearned premium claims. Claims by policyholders, beneficiaries, and insureds arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and liability claims against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and claims of guaranty associations or foreign guaranty associations. Notwithstanding the foregoing, the following claims shall be excluded from Class 2 priority:

(a) Obligations of the insolvent insurer arising out of reinsurance contracts;

(b) Obligations incurred after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this chapter. Notwithstanding this subsection, earned premium claims on policies, other than reinsurance agreements, shall not be excluded;

(c) Obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity or subrogation, equitable or otherwise;

(d) Any claim which is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer;

(e) Any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy; and

(f) Tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices.

(4) Claims of the federal government other than those claims included in Class 2.

(5) Wages.

(a) Debts due to employees for services performed, not to exceed one thousand dollars ($1,000) to each employee which have been earned within one (1) year before the filing of the petition for liquidation. Officers shall not be entitled to the benefit of this priority.

(b) This priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(6) Residual classification. All other claims including claims of the federal or any state or local government, not falling within other classes under this section. Claims, including those of any governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (9) of this section.

(7) Judgments. Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator who shall give the judgment such weight as he deems appropriate. The claim as allowed shall receive the priority it would receive in the absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment.

(8) Interest on claims already paid. Interest at the legal rate compounded annually on all claims in the classes under subsections (1) to (7) of this section, inclusive, from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the approval of the court may make reasonable classifications of claims for purposes of computing interest, may make approximate computations and may ignore certain classifications and time periods as de minimis.

(9) Miscellaneous subordinated claims. The remaining claims or portions of claims not already paid, with interest as in subsection (8) of this section:

(a) The first fifty dollars ($50) of each claim in the classes under subsections (2) to (7), inclusive, of this section, subordinated under this section;

(b) Claims under subsection (2) of KRS 304.33-380;

(c) Claims subordinated by KRS 304.33-600;

(d) Claims filed late;

(e) Portions of claims subordinated under subsection (6) of this section; and

(f) Claims or portions of claims, payment of which is provided by other benefits or advantages recovered or recoverable by the claimant.

(10) Preferred ownership claims. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Interest at the legal rate shall be added to each claim, as in subsections (8) and (9) of this section.

(11) Proprietary claims. The claims of shareholders or other owners.

Section 22. KRS 304.38-030 is amended to read as follows:

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

(1) "Commissioner" means the commissioner of insurance.

(2) "Enrollee" means a person who has been enrolled in a health maintenance organization.

(3)~~["Full service health maintenance organization" means a health maintenance organization that is authorized to provide all health care services.~~

~~(4)]~~ "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the health care services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a health maintenance organization are deemed to be "health benefit plans" to the extent defined in KRS 304.17A-005 unless exempted by the commissioner.

(4)~~[(5)]~~ "Health care services" means any services included in the furnishing to any individual of medical, optometric or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing, or healing human illness, physical disability or injury.

~~[(6) "Health discount plan" means:~~

~~(a) A person who provides, for a fee, a list of participating providers who will give the health discount plan's enrollees a specified discount from the provider's regular fees without recourse to the health discount plan;~~

~~(b) A provider, or provider organization that contracts with individuals or groups to provide a specific, predetermined set of routine services to the individual or group over the term of the contract in exchange for a fixed uniform fee paid by the enrollee without recourse to the health discount plan; or~~

~~(c) A combination of paragraphs (a) and (b) of this subsection.]~~

(5)~~[(7)]~~ "Health maintenance organization" means any person who undertakes to provide, directly or through arrangements with others, health care services to individuals enrolled with such an organization on a per capita or a predetermined, fixed prepayment basis. ***A health maintenance organization is authorized to provide all health care services***~~[Unless specifically stated, "health maintenance organization" shall include full service health maintenance organization, and single service organization]~~.

(6)~~[(8)]~~ "Person" includes, but is not limited to, any individual, partnership, association, trust, or corporation.

(7)~~[(9)]~~ "Provider" means a person or group of persons licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or another health profession in a state or licensed to act as a hospital or another health care facility.

~~[(10) "Single service organization" means a health maintenance organization that is authorized to provide only one (1) type of health care service, including dental, mental health, optometry, podiatry, vision, or some other single health service. Single service organizations holding a certificate of authority according to this subtitle shall be subject to the provisions of KRS 304.17A-270, 304.17A-505, 304.17A-525, 304.17A-530, 304.17A-590, and 304.17A-545(4).]~~

Section 23. KRS 304.38-035 is amended to read as follows:

No person shall in this state be, act as, or hold himself out as a health maintenance organization unless he holds a certificate of authority as a~~[full service]~~ health maintenance organization~~[, or a single service organization]~~ from the commissioner. ~~[Health discount plans shall not be required to hold a certificate of authority as a health maintenance organization but shall be required to hold a certificate of filing as defined in KRS 304.38-500.]~~

Section 24. KRS 304.38-060 is amended to read as follows:

Upon receipt of an application for issuance of a certificate of authority, the commissioner shall issue or deny the same. Issuance of a certificate of authority shall be granted only if the commissioner finds that the applicant has complied with KRS 304.38-040, has paid the application fee and the commissioner is satisfied that the following conditions are met:

(1) The persons responsible for the conduct of the affairs of the application are competent, trustworthy, and possess good reputations;

(2) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization or its inability to meet its financial obligations;

(d) Examples of any agreements with providers for the provision of health care services by provider type; and

(e) Compliance with KRS 304.38-070 if the applicant is applying for a~~[full service]~~ health maintenance organization certificate of authority~~[, or compliance with KRS 304.38-077 if the applicant is applying for a single service organization certificate of authority,]~~ as a guarantee that the obligations will be duly performed.

Section 25. KRS 304.38-073 is amended to read as follows:

Each~~[full service]~~ health maintenance organization shall furnish to the commissioner a deposit of cash or securities approved by the commissioner in an amount not less than five hundred thousand dollars ($500,000) so that the obligations to the enrollees shall be performed.~~[Each single service organization shall furnish to the commissioner a deposit of cash or securities approved by the commissioner, in an amount not less than fifty thousand dollars ($50,000) to ensure that the obligations to the enrollees shall be performed.]~~ A health maintenance organization may be required to furnish an additional deposit if the commissioner determines, after a hearing, that an additional deposit is necessary for the protection of the health maintenance organization's enrollees.

Section 26. KRS 304.38-191 is amended to read as follows:

Any group policy, group plan or group contract issued, delivered or renewed by a health maintenance organization shall include conversion and continuation rights for certificate holders equal to that provided in KRS 304.18-110 subject to the minimum benefits specified in KRS 304.18-120.~~[This section shall not apply to single service organizations.]~~

Section 27. 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 9 -- Agents, Consultants, Solicitors, and Adjusters;

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

(11) Subtitle 14 -- The Insurance Contract;

(12) Subtitle 17 -- Health Insurance Contracts;

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

(14) Subtitle 17B -- Kentucky Access;

(15) ***Subtitle 17C--Limited Health Services Benefit Plans;***

(16) Subtitle 18 -- Group and Blanket Health Insurance;

(17)~~[(16)]~~ Subtitle 24 -- Domestic Stock and Mutual Insurers;

(18)~~[(17)]~~ Subtitle 25 -- Continuity of Management;

(19)~~[(18)]~~ Subtitle 26 -- Insider Trading of Equity Securities;

(20)~~[(19)]~~ Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(21)~~[(20)]~~ Subtitle 37 -- Insurance Holding Company Systems;~~[and]~~

(22)~~[(21)]~~ ***Subtitle 47--Insurance Fraud; and***

(23) Subtitle 99 -- Penalties.

Section 28. KRS 304.42-050 is amended to read as follows:

As used in this subtitle:

(1) "Account" means either of the three (3) accounts created under KRS 304.42-060.

(2) "Association" means the Kentucky Life and Health Insurance Guaranty Association created under KRS 304.42-060.

(3) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specific amount. An assessment is authorized when the resolution is passed.

(4) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(5) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An

authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

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

(7) "Contractual obligation" means any obligation under a policy or contract or a certificate under a group policy or contract, or portion thereof, for which coverage is provided under KRS 304.42-030.

(8) "Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided under KRS 304.42-030.

(9) "Extracontractual claims" include, but are not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, and attorneys' fees and costs.

(10) "Impaired insurer" means a member insurer which, after June 17, 1978, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer which after June 17, 1978, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(12) "Member insurer" means any insurer authorized to transact in this state any kind of insurance for which coverage is provided under KRS 304.42-030, and includes any insurer whose certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(a) A nonprofit hospital, medical-surgical, dental, and health service corporation, as defined by Subtitle 32 of this chapter;

(b) A health maintenance organization;

(c) A fraternal benefit society;

(d) A mandatory state pooling plan;

(e) An assessment or cooperative insurer or any entity that operates on an assessment basis;

(f) An insurance exchange;

(g) Any entity similar to the above;~~[or]~~

(h) Health insurance where such insurance is written by a member of the Kentucky Insurance Guaranty Association***; or***

(i) A limited health service organization.

(13) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(14) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner," "contract owner," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(15) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. "Premiums" does not include amounts or considerations received for any policies or contracts or for the portions of policies or contracts for which coverage is not provided under KRS 304.42-030(2), except that assessable premium shall not be reduced on account of KRS 304.42-030(2)(b)3. Relative to interest limitations and KRS 304.42-030(3)(b) relating to limitations with respect to one (1) individual and one (1) contract owner. "Premiums" shall not include with respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of one million dollars ($1,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(16) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(17) "Plan sponsor" means:

(a) The employer in the case of a benefit plan established or maintained by a single employer;

(b) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(c) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one (1) or more employers and one (1) or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(18) (a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise the function, determined by the association in its reasonable judgment by considering the following factors:

1. The state in which the primary executive and administrative headquarters of the entity is located;

2. The state in which the principal office of the chief executive officer of the entity is located;

3. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

4. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

5. The state from which the management of the overall operations of the entity is directed; and

6. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(b) The principal place of business of a plan sponsor of a benefit plan described in subsection (17)(c) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan or question.

(19) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

(20) "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date when a member insurer is determined to be an impaired or insolvent insurer, whichever occurs first. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this subtitle shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(21) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(22) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(23) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(24) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

SECTION 29. A NEW SECTION OF KRS CHAPTER 367 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "health discount plan" means any card, program, device, or mechanism that is not insurance that purports to offer discounts or access to discounts from a health care provider without recourse to the health discount plan.

(2) No person shall sell, market, promote, advertise, or otherwise distribute a health discount plan unless:

(a) The health discount plan clearly states in bold and prominent type on all cards or other purchasing devices, promotional materials, and advertising that the discounts are not insurance;

(b) The discounts are specifically authorized by an individual and separate contract with each health care provider listed in conjunction with the health discount plan; and

(c) The discounts or the range of discounts advertised or offered by the plan are clearly and conspicuously disclosed to the consumer.

(3) The provisions of Subsection (2) do not apply to the following:

(a) A customer discount or membership card issued by a retailer for use in its own facility; or

(b) Any card, program, device, or mechanism that is not insurance and which is administered by a health insurer authorized to transact the business of insurance in this state.

(4) A violation of this section shall be deemed an unfair, false, misleading, or deceptive act or practice in the conduct of trade or commerce in violation of KRS 367.170. All of the remedies, powers, and duties delegated to the Attorney General by KRS 367.190 to 367.300 and penalties pertaining to acts and practices declared unlawful under KRS 367.170 shall be applied to acts and practices in violation of this section.

Section 30. KRS 304.33-020 is amended to read as follows:

The proceedings authorized by this subtitle may be applied to:

(1) All domestic insurers, whether or not they purport to do business in this state;

(2) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future;

(3) All insurers who purport to do an insurance business in this state;

(4) All insurers who have insureds resident in this state;

(5) All other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(6) All fraternal benefit societies as defined in Subtitle 29;

(7) All nonprofit hospital, medical-surgical, dental, and health service corporations, as defined in Subtitle 32;

(8) All health maintenance organizations as defined in Subtitle 38; and

(9) ***All limited health service organizations as defined in Section 10 of this Act***~~[Prepaid dental plan organizations as defined in KRS 304.43-010(6)]~~.

Section 31. KRS 304.12-013 is amended to read as follows:

(1) The purpose of this section is to prohibit unfair or deceptive practices in the transaction of life and health insurance with respect to the human immunodeficiency virus infection and related matters. This section applies to all life and health insurance contracts which are delivered or issued for delivery in Kentucky on or after July 13, 1990.

(2) This section shall not prohibit an insurer from contesting the validity of an insurance contract or whether a claim is covered under an insurance contract to the extent allowed by law.

(3) As used in this section:

(a) "Human immunodeficiency virus" (HIV) means the causative agent of acquired immunodeficiency syndrome (AIDS) or any other type of immunosuppression caused by the human immunodeficiency virus.

(b) "Insurance contract" means a contract issued by an insurer as defined in this section; and

(c) "Insurer" means an insurer, a nonprofit hospital, medical-surgical, dental, and health service corporation, a health maintenance organization, or a prepaid dental plan organization.

(4) (a) In the underwriting of an insurance contract regarding human immunodeficiency virus infection and health conditions derived from such infection, the insurer shall utilize medical tests which are reliable predictors of risk. Only a test which is recommended by the Centers for Disease Control or by the Food and Drug Administration is deemed to be reliable for the purposes of this section. If a specific Centers for Disease Control or Food and Drug Administration-recommended test indicates the existence or possible existence of human immunodeficiency virus infection or a health condition related to the human immunodeficiency virus infection, before relying on a single test to deny issuance of an insurance contract, limit coverage under an insurance contract, or to establish the premium for an insurance contract, the insurer shall follow the applicable Centers for Disease Control or Food and Drug Administration-recommended test protocol and shall utilize any applicable Centers for Disease Control or Food and Drug Administration-recommended follow-up tests or series of tests to confirm the indication.

(b) Prior to testing, the insurer shall disclose in writing its intent to test the applicant for the human immunodeficiency virus infection or for a specific health condition derived therefrom and shall obtain the applicant's written informed consent to administer the test. Written informed consent shall include a fair explanation of the test, including its purpose, potential uses and limitations, the meaning of its results, and the right to confidential treatment of information. Use of a form prescribed by the department shall raise a conclusive presumption of informed consent.

(c) An applicant shall be notified of a positive test result by a physician designated by the applicant, or, in the absence of such designation, by the Cabinet for Health Services. The notification shall include:

1. Face-to-face post-test counseling on the meaning of the test results, the possible need for additional testing, and the need to eliminate behavior which might spread the disease to others;

2. The availability in the geographic area of any appropriate health-care services, including mental health care, and appropriate social and support services;

3. The benefits of locating and counseling any person by whom the infected person may have been exposed to human immunodeficiency virus and any person whom the infected person may have exposed to the virus; and

4. The availability, if any, of the services of public health authorities with respect to locating and counseling any person described in subparagraph 3. of this paragraph.

(d) A medical test for human immunodeficiency virus infection or for a health condition derived from the infection shall only be required or given to an applicant for an insurance contract on the basis of the applicant's health condition or health history, on

the basis of the amount of insurance applied for, or if the test is required of all applicants.

(e) An insurer may ask whether an applicant for an insurance contract has been tested positive for human immunodeficiency virus infection or other health conditions derived from such infection. Insurers shall not inquire whether the applicant has been tested for or has received a negative result from a specific test for human immunodeficiency virus infection or for a health condition derived from such infection.

(f) Insurers shall maintain strict confidentiality of the results of tests for human immunodeficiency virus infection or a specific health condition derived from human immunodeficiency virus infection. Information regarding specific test results shall be disclosed only as required by law or pursuant to a written request or authorization by the applicant. Insurers may disclose results pursuant to a specific written request only to the following persons:

1. The applicant;
2. A licensed physician or other person designated by the applicant;
3. An insurance medical-information exchange under procedures that are used to assure confidentiality, such as the use of general codes that also cover results of tests for other diseases or conditions not related to human immunodeficiency virus infection;
4. For the preparation of statistical reports that do not disclose the identity of any particular applicant;
5. Reinsurers, contractually retained medical personnel, and insurer affiliates if these entities are involved solely in the underwriting process and under procedures that are designed to assure confidentiality;
6. To insurer personnel who have the responsibility to make underwriting decisions; and
7. To outside legal counsel who needs the information to represent the insurer effectively in regard to matters concerning the applicant.

(g) Insurers shall use for the processing of human immunodeficiency virus-related tests only those laboratories that are certified by the United States Department of Health and Human Services under the Clinical Laboratory Improvement Act of 1967, which permit testing of specimens in interstate commerce, and which subject themselves to ongoing proficiency testing by the College of American Pathologists, the American Association of Bioanalysts, or an equivalent program approved by the Centers for Disease Control.

(5) (a) An insurance contract shall not exclude coverage for human immunodeficiency virus infection. An insurance contract shall not contain benefit provisions, terms, or conditions which apply to human immunodeficiency virus infection in a different manner than those which apply to any other health condition. Insurance contracts which violate this paragraph shall be disapproved by the commissioner pursuant to KRS 304.14-130(1)(a), 304.32-160, ***and*** 304.38-050~~[, and 304.43-030]~~.

(b) A health insurance contract shall not be canceled or nonrenewed solely because a person or persons covered by the contract has been diagnosed as having or has been treated for human immunodeficiency virus infection.

(c) Sexual orientation shall not be used in the underwriting process or in the determination of which applicants shall be tested for exposure to the human immunodeficiency virus infection. Neither the marital status, the living arrangements, the occupation, the gender, the beneficiary designation, nor the zip code or other territorial classification of an applicant's sexual orientation.

(d) This subsection does not prohibit the issuance of accident only or specified disease insurance contracts.

Section 32. KRS 304.38-040 is amended to read as follows:

(1) A corporation, limited liability corporation, or partnership may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this subtitle.

(2) Health maintenance organizations which are corporations may be organized by applying the provisions of KRS Chapter 271B, if for profit, and KRS Chapter 273, if for nonstock, nonprofit, to the extent that the same are not inconsistent with the express provisions of this subtitle.

(3) Each application for a certificate of authority shall be submitted to the commissioner upon a form prescribed by him and shall set forth or be accompanied by:

(a) Evidence that the applicant has been issued a certificate of need in accordance with the provisions of KRS Chapter 216B, or evidence that no certificate of need is required by KRS Chapter 216B;

(b) Articles of incorporation or partnership agreement in quadruplicate originals acknowledged and verified by the applicant, such as the articles of incorporation, articles of association, partnership agreement, or other applicable documents;

(c) The initial bylaws of the organization in triplicate (or any other similar documents);

(d) A statement which shall include describing the health maintenance organization:

1. The health services to be offered;

2. The financial risks to be assumed;

3. The initial geographic area to be served;

4. Pro forma financial projections for the first three (3) years of operations including the assumptions the projections are based upon;

5. The sources of working capital and funding;

6. A description of the persons to be covered by the health maintenance organization;

7. Any proposed reinsurance arrangements;

8. Any proposed management, administrative, or cost-sharing arrangements; and

9. A description of the health maintenance organization's proposed method of marketing;

(e) The names, addresses, and positions of the initial board of directors, board of trustees, or other governing body responsible for the conduct of the affairs of the applicant;

(f) Any proposed evidence of coverage to be issued by the applicant to individuals, enrollees, groups, or other contract holders; and

(g) Evidence of financial responsibility as provided in KRS 304.38-060~~[or 304.38-077]~~.

Section 33. KRS 304.1-120 is amended to read as follows:

No provision of this code shall apply to:

(1) Fraternal benefit societies (as identified in Subtitle 29), except as stated in Subtitle 29.

(2) Nonprofit hospital, medical-surgical, dental, and health service corporations (as identified in Subtitle 32) except as stated in Subtitle 32.

(3) Burial associations (as identified in KRS Chapter 303), except as stated in Subtitle 31.

(4) Assessment or cooperative insurers (as identified in KRS Chapter 299), except as stated in KRS Chapter 299.

(5) Insurance premium finance companies (as identified in Subtitle 30), except as stated in Subtitle 30.

(6) Qualified organizations which issue charitable gift annuities within the Commonwealth of Kentucky. For the purposes of this subsection:

(a) A "qualified organization" means one which is:

1. Exempt from taxation under Section 501(c)(3) of the Internal Revenue Code as a charitable organization, if it files a copy of federal form 990 with the Division of Consumer Protection in the Office of the Attorney General; or

2. Exempt from taxation under Section 501(c)(3) of the Internal Revenue Code as a religious organization; or

3. Exempt as a publicly-owned or nonprofit, privately-endowed educational institution approved or licensed by the State Board of Education, the Southern Association of Colleges and Schools, or an equivalent public authority of the jurisdiction where the institution is located; and

(b) A "charitable gift annuity" means a giving plan or method by which a gift of cash or other property is made to a qualified organization in exchange for its agreement to pay an annuity.

(7) A religious publication (as identified in this subsection), or its subscribers, that limit their operations to those activities permitted by this subsection; and:

(a) Is a nonprofit religious organization;

(b) Is limited to subscribers who are members of the same denomination or religion;

(c) Acts as an organizational clearinghouse for information between subscribers who have financial, physical, or medical needs and subscribers who choose to assist with those needs, matching subscribers with the present ability to pay with subscribers with a present financial or medical need;

(d) Pays for the subscribers' financial or medical needs by payments directly from one (1) subscriber to another;

(e) Suggests amounts to give that are voluntary among the subscribers, with no assumption of risk or promise to pay either among the subscribers or between the subscribers and the publication; and

(f) Provides the following verbatim written disclaimer as a separate cover sheet for all documents distributed by or on behalf of the exempt entity, including all applications, guidelines, promotional or informational materials, and all periodic publications:

"This publication is not issued by an insurance company nor is it offered through an insurance company. This publication does not guarantee or promise that your medical bills will be published or assigned to others for payment.

Whether anyone chooses to pay your medical bills will be totally voluntary. This publication should never be considered as a substitute for an insurance policy.

Whether you receive any payments for medical expenses, and whether or not this publication continues to operate, you will always remain liable for any unpaid bills."

(8) A public or private ambulance service licensed and regulated by the Cabinet for Health Services to the extent that it solicits membership subscriptions, accepts membership applications, charges membership fees, and furnishes prepaid or discounted ambulance services to subscription members and designated members of their households.

Section 34. The following KRS sections are repealed:

304.43-010 Definitions.

304.43-020 Application for certificate of authority -- Continuance of existing organization.

304.43-030 Filing and approval of forms.

304.43-040 Issuance of certificate of authority.

304.43-050 Deposit.

304.43-060 Contract or certificate of services.

304.43-070 Annual and quarterly statements.

304.43-080 Agents -- Registration and licensing.

304.43-085 Coordination of benefits.

304.43-090 Examination of affairs of organization -- Report, confidentiality.

304.43-100 Suspension or revocation of certificate of authority.

304.43-110 Rehabilitation or liquidation.

304.43-120 Fees.

304.43-130 Advertisements or solicitation -- Cancellation of enrollee's coverage -- Applicability of Subtitle 12.

304.43-140 Conversion of prepaid dental plans to single service organization or health discount plan -- Reissuance of certificate of authority -- Net worth and risk-based capital requirements.

304.43-150 Filing of premium rates and classification of risks -- Commissioner's approval of filings required.

304.38-065 Certificate of authority to designate type of services authorized.

304.38-077 Single service organization -- Net worth and risk-based capital requirements.

304.38-500 Certificate of filing required for health discount plan -- Application and evidence of coverage requirements.

304.38-505 Plan disclosure requirements.

304.38-510 Suspension or revocation of certificate of filing -- Conditions -- Effect.

Approved March 28, 2002