CHAPTER 249

(HB 510)

AN ACT relating to health insurance.

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

Section 1. KRS 304.17A-245 is amended to read as follows:

(1) ***Except as provided in subsection (2) of this section, an***~~[Any]~~ insurer delivering or issuing a health benefit plan subject to this subtitle or a health insurance policy~~[or contract covering specified disease]~~ shall give the policyholder or contract holder at least ***thirty (30)***~~[forty-five (45)]~~ days' advance written notice of cancellation. The notice shall be mailed by ***regular United States first class***~~[registered]~~ mail to the policyholder's or contract holder's last address as shown by the records of the insurer. ***If premium has been paid, the insurer shall pay all claims through the conclusion of the thirty (30) day notice period, except for as provided in KRS 304.14-110.***

(2) ~~[However,]~~If cancellation is for nonpayment of premium, ***the insurer shall give the policyholder or contract holder at least thirty (30) days' written notice of cancellation. The cancellation shall be mailed by regular United States first class mail. If premium is not paid at the conclusion of the thirty (30) day grace period, the policy automatically terminates to the last date through which premium was paid. The insurer shall clearly state, in the thirty (30) day notice of termination, that if premium is not received by the end of the thirty (30) day grace period, the policy automatically terminates to the last date through which premium was paid***~~[at least fourteen (14) days' written notice accompanied by the reason therefor shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies in the individual market under which premiums are payable monthly or more frequently and regularly collected by a licensed agent]~~.

(3)~~[(2)]~~ ***If the group policy has been canceled, the insurer shall notify each group member of his right to conversion pursuant to KRS 304.18-110 within fifteen (15) business days after the end of the grace period.*** On and after January 1, 2001, every insurer offering group health insurance coverage in the Commonwealth shall include in its contract with group policyholders or contract holders, regardless of the situs of the contract, a provision requiring the group policyholder or contract holder to mail promptly to each person covered under the group policy or contract a legible, true copy of any notice of cancellation of the group coverage which may be received from the insurer and to provide promptly to the insurer proof of that mailing and the date thereof. The notice of cancellation mailed by the group policyholder or contract holder to each person covered under the group policy or contract shall include information regarding the conversion rights of covered persons upon termination of the group policy or contract. This information shall be in clear and easily understandable language.

(4) All group contracts shall include an automatic termination provision if premium amounts are not received by the end of the grace period.

(5)~~[(3)]~~ In the event of cancellation, the insurer shall return promptly the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(6)~~[(4)]~~ If the insurer fails to provide the ***thirty (30***)~~[forty-five (45)]~~ days' notice required by this section, the coverage shall remain in effect at the existing premium until ***thirty (30)***~~[forty-five (45)]~~ days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.

(7) In the case of nonpayment of premium, all group contracts shall include an insurer's reinstatement policy for a contract holder or policyholder. An insurer shall not deny a contract holder or policyholder reinstatement based on any health-related factor listed in KRS 304.17A-200 or consideration of medical loss ratio.

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

If premium is not paid by the premium due date, an insurer shall allow for a thirty (30) day grace period for which payments shall be paid by the policyholder or contract holder prior to termination of the policy.

Section 3. KRS 304.18-125 is amended to read as follows:

(1) ~~[If a group policy provides for automatic discontinuance of the policy after a premium charge has not been paid through a grace period allowed for the payment,]~~The insurer shall be liable for valid claims for covered losses incurred prior to the end of the grace period if the premium charge is paid prior to the end of the grace period.

(2)~~[If the actions of the insurer after the end of the grace period indicate that it considers the policy as continuing in force beyond the end of the grace period, such as by continuing to recognize claims incurred after the end of the grace period, the insurer shall be liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other person responsible for making premium payments to the insurer. The effective date of discontinuance shall not be prior to midnight at the end of the tenth scheduled work day after the date upon which the notice is mailed or delivered to the last known address of the policyholder or person responsible for making premium payments.~~

~~(3)]~~ This section shall not eliminate the responsibility of the insurer to notify persons of the right to continue or convert group health insurance coverage pursuant to KRS 304.18-110 and 304.18-120.

Section 4. KRS 304.17A-240 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

3. In exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph 2. of this paragraph, the insurer acts uniformly without regard to any health status-related factor of enrolled insureds or insureds who may become eligible for coverage.

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

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

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

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

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

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

include a reference to an association of which the individual is a member, and a reference to an employer member is deemed to include a reference to the employer.

Approved April 8, 2002