**CHAPTER 351**

**(HB 391)**

AN ACT relating to insurance.

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

Section 1. 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) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "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;

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

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

(6) "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;

(7) (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 (11) of this section;

(8) "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;

(9) "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 employer-organized association shall be treated as an association, small group, or large group under this subtitle;

(10) "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;

(11) "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;

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

(13) "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;

(14) "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;

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

(16) "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 or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(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;

(17) "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;

(18) "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 ***, or limited health service benefit plans***;

(19) "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) ***Advanced registered*** 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;

(20) (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;

(21) “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;

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

(23) “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;

(24) "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;

(25) ***"Kentucky Access" has the meaning provided in KRS 304.17B-001(17);***

***(26)*** “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;

***(27)***~~[(26)]~~ "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;

***(28)***~~[(27)]~~ “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;

***(29)***~~[(28)]~~ "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

***(30)***~~[(29)]~~ "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;

***(31)***~~[(30)]~~ "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

***(32)***~~[(31)]~~ "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;

***(33)***~~[(32)]~~ "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;

***(34)***~~[(33)]~~ "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;

***(35)***~~[(34)]~~ "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;

***(36)***~~[(35)]~~ "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

***(37)***~~[(36)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250.

***(38)***~~[(37)]~~ "Telehealth" has the meaning provided in KRS 311.550.

Section 2. 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) members: the commissioner plus eight (8) 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) 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;

(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 ***Section 7 of this Act***~~[subsection (5) of this section]~~;

(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(20) 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 3. KRS 304.17A-095 is amended to read as follows:

(1) (a) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to any market segment other than a large group shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers***. The insurer***~~[,]~~ shall ***also*** 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 ***shall submit a new filing to reflect any material change to the previously filed and approved rate filing. For all other changes, the insurer shall submit an amendment to a previously approved rate filing***~~[may submit new filings from time to time as it deems proper]~~.

(b) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to a large group as defined in KRS 304.17A-005 shall file the rating methodology with the commissioner and shall submit a copy of the filing to the Attorney General.

(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.]~~

***(b)***~~[(e)]~~ In the circumstances of a filing that has been deemed approved ***or has been disapproved*** 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 KRS 304.17B-021; 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 KRS 304.17B-021 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.

***(8) (a) The commissioner shall hold a hearing upon written request by the Attorney General. The written request shall be based upon one (1) or more of the reasons set out in subsection (3) of this section and shall state the applicable reasons.***

***(b) An insurer may request a hearing, pursuant to KRS 304.2-310, with regard to any action taken by the commissioner under this section as to the disapproval of rates or an order of a retroactive reduction of rates.***

***(c) The hearing shall be a public hearing conducted in accordance with KRS 304.2-310.***

Section 4. 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 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 KRS 304.17B-001 to 304.17B-031.

(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, or to arrange for an individual~~[ employee]~~ to apply to Kentucky Access, for the purpose of separating an ***individual***~~[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 provision 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) 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 KRS 304.17B-021. 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) The remedy provided by KRS 304.12-120 shall be available for conduct proscribed by this section.

(8) It is an unfair claims settlement practice for any person to make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the

payments are being made in instances in which the insured has a liability under the policy beyond his or her copayment or deductible.

Section 5. 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 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***; or***

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

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

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

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

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

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

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

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

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

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

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

Section 6. KRS 304.17A-669 is amended to read as follows:

(1) Nothing in KRS 304.17A-660 to 304.17A-669 shall be construed as mandating coverage for mental health conditions.

(2) The following shall be exempt from the provisions of KRS 304.17A-660 to 304.17A-669:

(a) A group health benefit plan covering fewer than ***fifty-one (51)***~~[fifty (50)]~~ employees;

(b) An individual health benefit plan; and

(c) An employer-organized association as defined in KRS 304.17A-005.

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

***(1) No less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established under KRS 304.17B-001(14) 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.***

***(2) The commissioner may by administrative regulation add to or delete from the list of high-cost conditions for Kentucky Access.***

Section 8. KRS 304.17B-015 is amended 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 ***one (1) insurer*** ~~[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 KRS 304.17B-001.

(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 ***effective*** 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 KRS 304.17B-019, 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 ***or the requirements of any administrative regulation promulgated under this subtitle*** may be terminated.

SECTION 9. A NEW SECTION OF SUBTITLE 18 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) As used in this section:***

***(a) "Conversion health insurance coverage" means a health benefit plan meeting the requirements of this section and regulated in accordance with Subtitles 17 and 17A of this chapter;***

***(b) "Group policy" has the meaning provided in Section 10 of this Act; and***

***(c) "Medicare" has the meaning provided in Section 10 of this Act.***

***(2) An insurer providing group health insurance coverage shall offer a conversion health insurance policy, by written notice, to any group member terminated under the group policy for any reason. The insurer shall offer a conversion health insurance policy substantially similar to the group policy. The former group member shall meet the following conditions:***

***(a) The former group member had been a member of the group and covered under any health insurance policy offered by the group for at least three (3) months;***

***(b) The former group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (5) of this section; and***

***(c) The former group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (5) of this section.***

***(3) An insurer shall offer the following terms of conversion health insurance coverage:***

***(a) Conversion health insurance coverage shall be available without evidence of insurability and may contain a pre-existing condition limitation in accordance with KRS 304.17A-230;***

***(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:***

***1. The effective date of the conversion policy; or***

***2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;***

***(c) The conversion health insurance policy shall cover the former group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated.***

***(d) The effective date of the conversion health insurance policy shall be the date of termination of coverage under the group policy; and***

***(e) The conversion health insurance policy shall provide benefits substantially similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120 and any administrative regulations promulgated thereunder.***

***(4) Conversion health insurance coverage need not be granted in the following situations:***

***(a) On the effective date of coverage, the applicant is or could be covered by Medicare;***

***(b) On the effective date of coverage, the applicant is or could be covered by another group coverage (insured or uninsured) or, the applicant is covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or***

***(c) The issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection.***

***(5) Notice of the right to conversion health insurance coverage shall be given as follows:***

***(a) For group policies delivered, issued for delivery, or renewed after the effective date of this Act, the insurer shall give written notice of the right to conversion health insurance coverage to any former group member entitled to conversion coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group, upon termination of the former group member's continued group health insurance coverage pursuant to Section 10 of this Act or COBRA as defined in subsection (6) of Section 1 of this Act, or upon termination of the group policy for any reason. The written notice shall clearly explain the former group member's right to a conversion policy.***

***(b) The thirty-one (31) day period of subsection (2)(b) of this section shall not begin to run until the notice required by this subsection is mailed or delivered to the last known address of the former group member.***

***(c) If a former group member becomes entitled to obtain conversion health insurance coverage, pursuant to this section, and the insurer fails to give the former group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of conversion rights to the former group member and such former group member shall have an additional period within which to exercise his conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the former group member shall constitute the giving of notice for the purpose of this paragraph. If a former group member makes application and pays the premium, for conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage. However, nothing in this subsection shall require an insurer to give notice or provide conversion coverage to a former group member ninety (90) days after termination of the former group member's group coverage.***

Section 10. KRS 304.18-110 is amended to read as follows:

(1) As used in this section:

(a) "Group policy" means group health insurance policies as defined in KRS 304.18-020 and blanket health insurance policies which the commissioner, in his discretion, designates as subject to this section, which:

1. Affect the rights of a Kentucky insured and bear a reasonable relation to Kentucky, regardless of whether delivered or issued for delivery in Kentucky;

2. Provide hospital or surgical expenses benefits, other than for a specific disease or accidental injury only; and

3. Are delivered, issued for delivery, or renewed after ***the effective date of this Act***~~[July 15, 1986]~~;

(b) "Medicare" means Title XVIII of the United States Social Security Act as amended or superseded.

(2) Persons insured under group policies have the right upon termination of group membership to continue coverage for themselves and their dependents upon meeting the following conditions:

(a) The group member has been covered by the group policy or any group policy it replaced for at least three (3) months; and

(b) Notice is given to the insurer and payment of the group rate is made to the insurer***, by the group member,*** within thirty-one (31) days after notice pursuant to subsection ***(7)***~~[(9)]~~ of this section.

(3) Continued group health insurance coverage shall terminate on the earlier of:

(a) The date eighteen (18) months after the date on which the group coverage would otherwise have terminated because of termination of group membership;

(b) If the group member fails to make timely payment of premium to the insurance company, the end of the period for which premium payment was made; or

(c) The date the group policy is terminated and is not replaced by another group policy within thirty-one (31) days.

(4) If a group policy is replaced, ***by a succeeding insurer,*** persons under the continued group health insurance shall remain ***covered under the prior insurer's***~~[under such coverage under the replaced]~~ policy until it terminates in accordance with subsection (3) of this section.

(5) ~~[Group members have the right upon termination of coverage under a group policy for any reason to have a conversion health insurance policy providing substantially similar benefits issued to the group member by the insurer upon meeting the following conditions:~~

~~(a) The group member has been covered by the group policy or any policy it replaced for at least three (3) months;~~

~~(b) The group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (9) of this section; and~~

~~(c) The group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (9) of this section.~~

~~(6) Terms of conversion health insurance coverage:~~

~~(a) Conversion health insurance coverage shall be available without evidence of insurability and shall contain no pre-existing condition limitations;~~

~~(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:~~

~~1. The effective date of the converted policy; or~~

~~2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;~~

~~(c) The conversion health insurance policy shall cover the group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated;~~

~~(d) The effective date of the conversion health insurance policy shall be the date of termination of coverage under the group policy; and~~

~~(e) The conversion health insurance policy shall provide benefits substantially similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120.~~

~~(7) [~~The right to continue group health insurance coverage ~~[and the right to conversion health insurance coverage ]~~shall also be available:

(a) To the surviving spouse, at the death of the group member, with respect to the spouse and such children whose coverage under the group policy would terminate or terminates by reason of the death of the group member;

(b) To a child solely with respect to himself upon termination of membership in the group or his coverage by reason of operation of the limiting age of coverage under the group policy while covered as a dependent thereunder; or

(c) To a former spouse for himself and such children of whom he is awarded custody when coverage under the group policy would terminate or terminates by reason of termination of dependency as defined in the group policy and resulting from an order dissolving the marriage entered by a court of competent jurisdiction.

***(6)*** ~~[(8)]~~ Continuation of group health insurance coverage ~~[or conversion health insurance coverage ]~~need not be granted in the following situations:

(a) ***On the effective date of coverage,*** the applicant is or could be covered by Medicare;

(b) ***On the effective date of coverage,*** the applicant is or could be covered by another group coverage (insured or uninsured)~~[ or, in the case of conversion health insurance coverage, the applicant is covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or~~

~~(c) In the case of conversion health insurance coverage, the issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection~~].

***(7)*** ~~[(9)]~~ Notice of the right to continue group health insurance coverage ~~[and the right to conversion health insurance coverage ]~~shall be given as follows:

(a)~~[ 1.]~~ For group policies delivered, issued for delivery, or renewed after ***the effective date of this Act***~~[July 15, 1986]~~, the insurer shall give written notice of the right to continue group health insurance coverage ~~[and the right to conversion health insurance coverage ]~~to any group member entitled to continue coverage ~~[or to conversion~~

~~coverage ~~]under this section upon notice from the group policyholder that the group member has terminated membership in the group~~[ or upon termination of continued group health insurance coverage]~~. The thirty-one (31) day period of ***subsection***~~[subsections]~~ (2)(b)~~[ and (5)(b)]~~ of this section shall not begin to run until the notice required by this paragraph is mailed or delivered to the last known address of the group member;~~[ and~~

~~2. Upon replacement of a group policy, the replacing insurer shall determine if there are group members who were covered under the previous group policy who are not covered under the replacing group policy. The replacing insurer shall by writing notify the insurer which issued the previous group policy of such lack of coverage and the insurer which issued the previous group policy shall issue the notice required by paragraph (a) of this subsection;]~~

(b) If a group member becomes entitled to obtain continued health insurance coverage~~[ or conversion health insurance coverage]~~ pursuant to this section***,*** and ***the insurer fails to give the group member written notice of the right,***~~[if such group member has not been given written notice of these rights]~~ pursuant to this subsection, ***the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of continuation rights to the group member and*** such group member shall have an additional period within which to exercise continuation or conversion rights***. The additional period shall expire sixty (60) days after written notice is received from the insurer.*** ~~[as follows:~~

~~1. The additional period shall expire fifteen (15) days after the group member is given notice, but in no event shall the additional period extend beyond sixty (60) days after the expiration of the thirty-one (31) day period following termination from the group or termination of group coverage;~~

~~2. ~~]Written notice delivered or mailed to the last known address of the group member shall constitute the giving of notice for the purpose of this paragraph***.***~~[; and~~

~~3. ~~] If a group member makes application and pays the premium for continued health insurance coverage~~[ or conversion health insurance coverage]~~ within the additional period allowed by this paragraph, the effective date of continued health insurance coverage shall be the date of termination from the group***. However, nothing in this subsection shall require an insurer to give notice or provide continuation coverage to a former group member ninety (90) days after termination of the former group member's group coverage.***~~[ and the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage.~~

~~(10) Before a group policy may be replaced, the employer shall give at least thirty (30) days' written notice by certified mail to any employee covered under the replaced policy who will not be covered under the new policy.]~~

Section 11. KRS 304.18-126 is amended to read as follows:

(1) ***As used in this section, "disability" means the state of being hospitalized on the date of replacement coverage or coverage under an extension of benefits provision.***

***(2) An insurer offering group health insurance, as defined in KRS 304.18-020,***~~[A group policy]~~ shall provide ***for an***~~[a reasonable provision for]~~ extension of benefits in the event of

***a member's*** total disability at the date of discontinuance of the group policy or contract in accordance with this section.

***(3)*** ~~[(2)]~~ ***Benefits payable under an extension of benefits shall be limited to the member's hospital confinement or period of total disability for a specific condition, injury, or illness that resulted in the member's total disability*** ~~[If the group policy provides benefits for loss of time from employment or specific indemnity during hospital confinement, discontinuance of the policy during a disability shall have no effect on benefits payable for that disability or confinement]~~.

***(4)*** ~~[(3)]~~ In the case of hospital or medical expense coverages, a reasonable extension of benefits or accrued liability shall be required. A provision shall be considered reasonable ***if***:

(a) Under major medical coverages ***for hospital confinement,*** ~~[ if]~~ it provides an extension ***until the earlier of one (1) of the following:***

***1. Discharge from the hospital confinement;***

***2. Until maximum benefits under the policy are received; or***

***3.*** ~~[of ]~~At least twelve (12) months***.*** ~~[; and]~~

(b) ***Under major medical coverage for a period of total disability, it provides an extension of benefits until the earlier of one (1) of the following:***

***1. Until coverage for the total disability has been obtained under another group policy;***

***2. Until the total disability ceases;***

***3. Until maximum benefits under the policy are received; or***

***4. At least twelve (12) months.***

***(c)*** Under other types of hospital or medical expense coverages***,*** ~~[ if]~~ it provides an extension of at least ninety (90) days for expenses incurred during the period of ***total*** disability or ***hospital confinement or*** incurred within a period of at least ninety (90) days starting with a specific event which occurred while coverage was in force, such as an accident.

***(5)*** ~~[(4)]~~ ***Coverage for a total disability shall not be considered to have been obtained under a succeeding plan, whether it be fully insured or self-insured, if the succeeding plan excludes coverage for the total disability covered under the prior plan's extension of benefits provision.***

***(6)*** Any applicable extension of benefits or accrued liability shall be described in the group policy as well as in group insurance certificates ~~[. The benefits payable during the period of extension or accrued liability may be subject to the group policy's regular benefit limits, such as benefits ceasing at exhaustion of a benefit period or a maximum benefit limitation]~~.

Section 12. KRS 304.18-127 is amended to read as follows:

(1) This section shall indicate the insurer responsible for liability in those instances in which one (1) insurer's group policy replaces the group policy of another insurer.

(2) The prior insurer shall remain liable only to the extent of its accrued liabilities, ***extension*** ~~[extensions]~~ of benefits, and for persons who are under continued group health insurance coverage pursuant to KRS 304.18-110 at the time the group policy terminates.

The position of the prior insurer shall be the same whether the group policyholder secures replacement coverage from a new insurer, self insures, or forgoes the provision of a group policy, except that termination of continued group health insurance coverage shall occur in accordance with KRS 304.18-110 ***and Section 9 of this Act***.

(3) The liability of a succeeding insurer shall be as follows:

(a) Each person who is eligible for coverage~~[ in accordance with the succeeding insurer's plan of benefits, in respect to classes eligible, actively at work, and nonconfinement rules,]~~ shall be covered by that insurer's plan ***on the effective date of coverage and in accordance with KRS 304.17A-200***~~[of benefits]~~.

(b) ***If a person, who is eligible for coverage, is confined as of the effective date of coverage under the succeeding insurer's plan and the succeeding insurer has a nonconfinement rule, the succeeding insurer is not responsible for the cost of the person's confinement to the extent that the confinement is covered by a prior insurer's extension of benefits provision, in accordance with Section 11 of this Act***~~[Each person not covered under the succeeding insurer's plan of benefits in accordance with paragraph (a) of this subsection shall nevertheless be covered by the succeeding insurer in accordance with the following provisions if the person was validly covered, including benefit extensions, under the prior insurer on the date of termination of the prior insurer's group policy and if the person is a member of the class or classes of persons eligible for coverage under the succeeding insurer's plan. Any reference in the following provisions to a person who was or was not totally disabled shall be a reference to that person's status immediately prior to the date the succeeding insurer's coverage becomes effective.~~

~~1. The minimum level of benefits to be provided by the succeeding insurer shall be the applicable level of benefits of the prior insurer's group policy reduced by any benefits payable by the prior insurer under its group policy.~~

~~2. Coverage shall be provided by the succeeding insurer until at least the earliest of the following dates:~~

~~a. The date the person becomes insured according to paragraph (a) of this subsection;~~

~~b. For each type of coverage, the date the person's coverage would terminate in accordance with the succeeding insurer's group policy provisions applicable to individual termination of coverage; or~~

~~c. In the case of a person who was totally disabled and the type of coverage is one for which KRS 304.18-126 requires an extension of accrued liability, the end of extension of accrued liability which is required of the prior insurer by KRS 304.18-126, or, if the prior insurer's group policy is not subject to KRS 304.18-126, would have been required of that insurer had its group policy been subject to KRS 304.18-126 at the time the prior insurer's group policy was discontinued and replaced by the succeeding insurer's plan.~~

~~(c) In the case of a pre-existing conditions limitation in the succeeding insurer's group policy, the level of benefits applicable to pre-existing conditions of persons becoming covered by the succeeding insurer's plan in accordance with this subsection during the~~

~~period of time this limitation applies under the succeeding insurer's group policy shall be the lesser of:~~

~~1. The benefits of the succeeding insurer's group policy determined without application of the pre-existing conditions limitation; or~~

~~2. The benefits of the prior insurer's group policy~~].

***(c)*** ~~[(d)]~~ The succeeding insurer, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior group policy. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior insurer's group policy during the ninety (90) days preceding the effective date of the succeeding insurer's group policy, but only to the extent these expenses are recognized under the terms of the succeeding insurer's group policy and are subject to similar deductible provisions.

***(d)*** ~~[(e)]~~ If a determination of the prior insurer's benefit is required by the succeeding insurer, at the succeeding insurer's request the prior insurer shall furnish a statement of the benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the succeeding insurer. For purposes of this section, benefits of the prior insurer's group policy shall be determined in accordance with all of the definitions, conditions, and covered expense provisions of the prior insurer's group policy rather than those of the succeeding insurer's group policy. The benefit determination shall be made as if coverage had not been replaced by the succeeding insurer.

Section 13. KRS 304.40-075 is amended to read as follows:

(1) As used in this section, unless the context requires otherwise:

(a) "Charitable health care provider" means any person, agency, clinic, or facility licensed or certified by the Commonwealth, or under a comparable provision of law of another state, territory, district, or possession of the United States, engaged in the rendering of medical care without compensation or charge, and without expectation of compensation or charge, to the individual, without payment or reimbursement by any governmental agency or insurer. "Charitable health care provider" only means those persons, agencies, clinics, or facilities engaging in primary care medicine and performing no invasive or surgical procedures;

(b) "Medical malpractice insurer" means every person or entity engaged as principal and as indemnitor, surety, or contractor in the business of entering into contracts to provide medical professional liability insurance, except an entity in the business of providing such medical professional liability insurance only to itself or its affiliated subsidiary, or parent corporation, or subsidiaries of its parent corporations; and

(c) "Medical professional liability insurance" means insurance to cover liability incurred as a result of the hands-on providing of medical professional services directly to patients by an insured in the treatment, diagnosis, or prevention of patient illness, disease, or injury.

(2) Insurers offering medical professional liability insurance in the Commonwealth shall make available, as a condition of doing business in the Commonwealth pursuant to this chapter,

medical professional liability insurance for charitable health care providers and persons volunteering to perform medical services for charitable health care providers, with the same coverage limits made available to its other insureds.

(3) (a) Premiums for policies issued under subsection (2) of this section shall be paid by the Commonwealth from the general fund upon written application for payment of the premium by the health care provider wishing to offer charitable services.

(b) The Department of Insurance shall, through promulgation of administrative regulations pursuant to KRS Chapter 13A, establish reasonable guidelines for the registration of charitable health care providers. The guidelines shall require the provider to supply, at a minimum, the following information:

1. Name and address of the charitable health care provider;

2. Number of employees of the charitable health care provider who will be rendering medical care without compensation or charge and without expectation of compensation or charge, and who will be covered under the policy issued under subsection (2) of this section;

3. The expected number of patients to be provided charitable health care services in the year for which the insurer will offer malpractice coverage;

4. The charitable health care provider's acknowledgment that the insurer's risk management and loss prevention policies shall be followed;~~[ and]~~

5. A copy of the registration filed with the Cabinet for Health Services under KRS 216.941***; and***

***6. A copy of the medical malpractice policy, declaration page, and any other documentation the commissioner may deem necessary to determine the proper amount of premiums and taxes to be reimbursed***.

(c) Persons insured under this section shall be required to comply with the same risk management and loss prevention policies which the insurer imposes upon its other insureds.

***(d) Any premium refund for medical professional liability insurance issued under subsection (2) of this section received for any reason by the charitable health care provider shall be promptly remitted to the department for transmittal to the general fund.***

(4) This section shall only apply to charitable health care providers and persons volunteering to perform medical services for charitable health care providers who are not otherwise covered by any policy of medical professional liability insurance for the charitable health care services provided, and that meet the terms for eligibility established pursuant to this section.

(5) Coverage offered to charitable health care providers and persons volunteering at charitable health care providers shall be at least as broad as the coverage offered by the insurer to other noncharitable health care providers or facilities and to medical professionals working at noncharitable health care facilities.

(6) The Department of Insurance shall retrospectively review on an annual basis the premiums paid pursuant to this section as opposed to the expenses incurred by the insurers covering risks under this section to determine if the profits made for those risks were consistent with reasonable loss ratio guidelines. If the determination is made that the profits were not

consistent with reasonable loss ratio guidelines, the Department of Insurance shall determine the amount of the premiums to be refunded to the Commonwealth.

(7) The Cabinet for Health Services shall make available to the Department of Insurance information on its registration of charitable health care providers for the purpose of obtaining medical malpractice insurance.

(8) The Department of Insurance shall not provide medical malpractice insurance as specified in subsection (3)(a) of this section to a charitable health care provider who has not registered with the Cabinet for Health Services under KRS 216.941.

SECTION 14. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***In connection with rental reimbursement coverage under an automobile insurance policy, an insurer, an employee or representative of an insurer, an agent of an insurer, a consultant, or an insurance adjuster shall not:***

***(1) Solicit or accept a referral fee or gratuity in exchange for referring an insured or claimant to a rental vehicle agency;***

***(2) State or suggest, either orally or in writing, to an insured or claimant that a specific rental vehicle agency must be used to be covered under the policy; or***

***(3) In any way restrict the insured's or claimant's right to choose a rental vehicle agency.***

Section 15. 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. ***However, upon any policy issuance or renewal, on or after January 1, 2003, the maximum variation shall revert to thirty-five percent (35%) of the index rate.***

(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 percent (20%) 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) 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 ***fifty percent (50%)***~~[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) 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 percent (20%) 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) 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) 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) 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) 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) 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) 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 16. 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 insurer-controlled;

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. 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;

(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 employer-organized 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 ***fifty percent (50%)*** ~~[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 employer-organized 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 percent (20%) 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 17. KRS 18A.225 is amended to read as follows:

(1) (a) The term "health maintenance organization" for the purposes of this section means a health maintenance organization as defined in KRS 304.38-030 or as a nonprofit hospital, medical-surgical, dental, and health service corporation, which has been licensed by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board or its successor agency and issued a certificate of authority by the Department of Insurance as a health maintenance organization or as a nonprofit hospital, medical-surgical, dental, and health service corporation and which is qualified under the requirements of the United States Department of Health, Education and Welfare except as provided in subsection (2) of this section; and

(b) The term "state employee" for purposes of this section shall include a person, including an elected public official, who is regularly employed by any department, board, agency, branch of state government, or any municipal, urban-county, charter county, or county government, whose legislative body has opted to participate in the state health insurance program pursuant to KRS 79.080 and who is a contributing member to any one (1) of the retirement systems administered by the state. It shall also include a person who must fulfill the requirements established by the Kentucky Board of Education for eligibility and a person who is a present or future recipient of a retirement allowance from any of the Kentucky Retirement Systems who either satisfies the requirements of KRS 61.559 or who is board authorized under KRS 61.702(1), including a beneficiary of a retired employee as defined in KRS 61.542 who is receiving a retirement allowance from any of the Kentucky Retirement Systems and includes members of the Legislators' Retirement Plan as provided in KRS 18A.2287. It shall also include a person who is a present or future recipient of a retirement allowance from the Teachers' Retirement System of Kentucky who either satisfies the requirements of KRS 161.525, 161.620, and 161.675 or who is board certified, including a beneficiary of a retired member who is receiving a retirement allowance from the Teachers' Retirement System of Kentucky, except that a member who is receiving a retirement allowance from the Teachers' Retirement System and who is age sixty-five (65) or older shall not be included.

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more health insurance companies or from one (1) or more health maintenance organizations authorized to do business in this state, a policy or policies of group health care coverage including, but not limited to, indemnity, health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of state employees. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994. All state employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the state or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment. For calendar year 2001 only, an emergency shall exist when any county in which only one (1) health insurance company offers a single plan to state employees and, subsequent to the open enrollment period, the health insurance company fails to maintain at least sixty-five percent (65%) of its contracts within the geographic region with specialty physicians who were participating in the network at the time of open enrollment. The Finance and Administration Cabinet shall immediately notify the Governor, the Legislative Research Commission, and the secretary of the Personnel Cabinet and shall be authorized to immediately negotiate and contract with additional health insurance companies for additional plans to serve any county without meeting the requirements of the Model Procurement Code under KRS Chapter 45.

(b) The policy or policies shall be approved by the commissioner of insurance and may contain the provisions he approves, whether or not otherwise permitted by the insurance laws.

(c) Any carrier bidding to offer health care coverage to members of the state group shall agree to provide coverage to all members of the state group, including both active employees and retirees within the county or counties specified in its bid. Furthermore, any carrier bidding to offer health care coverage to members of the state group shall also agree to rate all such members of the state group as a single entity, except for those retirees whose former employers insure their active employees outside the state health insurance program.

(d) Any carrier bidding to offer health care coverage to any member of the state group shall agree to provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance of data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions to protect the confidentiality of each individual member; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier and shall develop methods to protect the confidentiality of the individual. The Personnel Cabinet shall provide to the General Assembly in June of each year an analysis of enrollment, claims, utilization data of all carriers for the prior plan year ending December 31, and on the financial stability of the program. The report shall include, but not be limited to, loss ratios, methods of risk adjustment, measurements of carrier quality of service, prescription coverage and cost management, paid dependent coverage, and statutorially required mandates. If state self-insurance was available as a carrier option, the report also shall provide a detailed financial analysis of the self-insurance fund including, but not limited to, loss ratios, reserves, and reinsurance agreements.

(f) If any agency participating in the state employee health insurance program for its active members terminates participation in the state employee health insurance program for its active members and there is a state appropriation for the employer's contribution for active employees' health insurance coverage, neither the agency nor the employees shall receive the state-funded contribution after termination from the state employee health insurance program.

(g) Any funds in flexible spending accounts that remain after all reimbursements have been processed shall be transferred to the credit of the state health insurance plan's appropriation account.

(3) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, may procure from one (1) or more dental insurance companies, one (1) or more nonprofit hospital, medical-surgical, dental, and health service

corporations organized under Subtitle 32 of KRS Chapter 304, or one (1) or more prepaid dental plan organizations organized under Subtitle 43 of KRS Chapter 304, a policy or policies of group dental insurance or prepaid dental plan coverage encompassing all or any class or classes of state employees. All state employees for whom the dental insurance or prepaid dental plan coverage is provided shall annually be given an option to elect either standard dental insurance coverage or coverage by a prepaid dental plan. The policy or policies shall be approved by the commissioner of insurance and may contain the provisions he approves, whether or not otherwise permitted by the insurance laws. It is intended that either dental insurance or prepaid dental plan coverage may be made available for state employees, except that the procuring of each is permissive.

(4) The premiums may be paid by the policyholder:

(a) Wholly from funds contributed by the insured employee, by payroll deduction or otherwise;

(b) Wholly from funds contributed by any department, board, agency, or branch of state, municipal, urban-county, charter county, or county government; or

(c) Partly from each, except that any premium due for health care coverage or dental coverage, if any, in excess of the premium amount contributed by any department, board, agency, or branch of state, municipal, urban-county, charter county, or county government for any other health care coverage shall be paid by the employee.

(5) If an employee moves his place of residence or employment out of the service area of a managed health care plan or of a prepaid dental plan, under which he has elected coverage, into either the service area of another managed health care plan or prepaid dental plan or into an area of the state not within a managed health care plan service area or prepaid dental plan service area, the employee shall be given an option, at the time of the move or transfer, to change his or her coverage to another health care plan or dental plan.

(6) No payment of premium by any department, board, agency, or branch of state, municipal, urban-county, charter county, or county government shall constitute compensation to an insured employee for the purposes of any statute fixing or limiting the compensation of such an employee. Any premium or other expense incurred by any department, board, agency, or branch of state, municipal, urban-county, charter county, or county government shall be considered a proper cost of administration.

(7) The policy or policies may contain the provisions with respect to the class or classes of employees covered, amounts of insurance or coverage for designated classes or groups of employees, policy options, terms of eligibility, continuation of insurance or coverage after retirement, and other provisions the commissioner of insurance may approve.

(8) The policy or policies shall contain the provision that employees or retired employees shall be allowed to change health care plans during the reopening period without any limitation for pre-existing conditions if the employee has met the pre-existing condition limitation upon initial employment or reemployment with the group.

(9) The secretary of the Finance and Administration Cabinet is authorized to perform all acts necessary or advisable for the purpose of contracting for and maintaining health care coverage and dental coverage under the provisions of this section.

(10) Group rates under this section shall be made available to the disabled child of a state employee regardless of the child's age if the entire premium for the disabled child's coverage

is paid by the state employee. A child shall be considered disabled if he has been determined to be eligible for federal Social Security disability benefits.

(11) The health care contract or contracts for state employees shall be entered into for a period of not less than one (1) year.

(12) The secretary shall appoint twenty-eight (28) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or his designee regarding the state health insurance program for state employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

(13) Notwithstanding any other provision of law to the contrary, the policy or policies provided to state employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the purpose of obtaining or performing an abortion on behalf of state employees or their dependents.

(14) Interruption of an established treatment regime with maintenance drugs shall be grounds for an insured to appeal a formulary change through the established appeal procedures approved by the Personnel Cabinet, if the physician supervising the treatment certifies that the change is not in the best interests of the patient.

***(15) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services and magnetic resonance imaging services, the employee may select a plan available in a contiguous county that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.***

Section 18. The following KRS sections are repealed:

304.17A-137 Coverage for prescribed cancer drugs not approved by the Federal Food and Drug Administration for cancer treatment -- Review panel for off-label uses.

304.17A-260 Approval to reenter state for insurer that ceased doing business after July 15, 1995, and before April 10, 1998.

**Approved April 23, 2002**