CHAPTER 157

(HB 508)

AN ACT relating to insurance.

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

Section 1. KRS 304.14-650 is amended to read as follows:

As used in KRS 304.14-650 to 304.14-675, "short-term nursing home insurance policies" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for less than twelve (12) consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one (1) or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital unless the hospital or unit is licensed or certified to provide services in a skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, personal care facility, home health care agency, adult day care facility, and assisted living facility. This term shall also include a policy or rider that provides for payment of benefits based upon cognitive impairment or loss of functional capacity. Short-term nursing home insurance policies may be issued by insurers, fraternal benefit societies, nonprofit hospitals, medical-surgical, dental, and health services corporations, health maintenance organizations, or any similar organization to the extent they are otherwise authorized to issued life or health insurance. Short-term nursing home insurance policies shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity, major medical expense coverage, disability income or related-asset protection coverage, accident only coverage, specified disease or specified accident coverage~~[, or limited benefit coverage]~~.

Section 2. KRS 304.17A-245 is amended to read as follows:

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

(2) If cancellation is for nonpayment of premium, the insurer shall give the policyholder or contract holder at least thirty (30) days' written notice of cancellation. The cancellation shall be mailed by regular United States first class mail. If premium is not paid at the conclusion of the thirty (30) day grace period, the policy automatically terminates to the last date through which premium was paid. The insurer shall clearly state, in the thirty (30) day notice of termination, that if premium is not received by the end of the thirty (30) day grace period, the policy automatically terminates to the last date through which premium was paid.

(3) If the group policy has been canceled, the insurer shall notify each group member of his right to conversion pursuant to KRS 304.18-110 within fifteen (15) business days after the end of the grace period. On and after January 1, 2001, every insurer offering group health insurance coverage in the Commonwealth shall include in its contract with group policyholders or contract holders, regardless of the situs of the contract, a provision

requiring the group policyholder or contract holder to mail promptly to each person covered under the group policy or contract a legible, true copy of any notice of cancellation of the group coverage which may be received from the insurer and to provide promptly to the insurer proof of that mailing and the date thereof. The notice of cancellation mailed by the group policyholder or contract holder to each person covered under the group policy or contract shall include information regarding the conversion rights of covered persons upon termination of the group policy or contract. This information shall be in clear and easily understandable language.

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

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

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

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

Section 3. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan as defined in KRS 304.17A-500 shall file with the commissioner sample copies of any agreements it enters into with providers for the provision of health care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements and contracts entered into or renewed after July 15, 2002, shall include the following:

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

1. Nonpayment of moneys due the providers by the managed care plan,

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

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

(b) A continuity of care clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than a quality of care issue or fraud, the ***insurer*** ~~[provider]~~ shall continue to provide services and reimburse the provider in accordance with the agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course

of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy;

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

(d) A clause stating that, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request; and

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

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

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

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

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

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

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

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

Section 4. KRS 304.38-191 is amended to read as follows:

Any group policy, group plan, or group contract issued, delivered, or renewed by a health maintenance organization shall include ***continuation rights for certificate holders, pursuant to KRS 304.18-110, and*** conversion~~[and continuation]~~ rights for certificate holders equal to that provided in KRS ***304.18-114***~~[304.18-110]~~ subject to the minimum benefits specified in KRS 304.18-120.

Section 5. KRS 304.10-050 is amended to read as follows:

At the time of effecting any such surplus lines insurance, the broker shall execute an affidavit in form prescribed or accepted by the commissioner setting forth facts from which it can be determined whether such insurance was eligible for export under KRS 304.10-040. The broker shall file this affidavit with the commissioner ***in the manner and form as prescribed by the commissioner through administrative regulation***~~[within sixty (60) days after the insurance was so effected, except where an alien insurer was used, in which case the broker shall file such affidavit within ninety (90) days]~~.

Approved April 22, 2004