CHAPTER 144

(HB 278)

AN ACT relating to health insurance and declaring an emergency.

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

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

(1) Any insurer issuing or delivering group health benefit plans in the Commonwealth shall provide to an employer-organized association health benefit plan, within thirty (30) calendar days after a written request, the information relating to its health benefit plan that has been requested, including but not limited to the following information for the previous three (3) years or for the entire period of coverage, whichever is shorter:

(a) Aggregate claims experience, by month, including claims experience for pharmacy benefits;

(b) Total premiums paid, by month;

(c) Total number of insureds on a monthly basis, by coverage tier; and

(d) Sufficient detailed claims information to permit the employer-organized association to verify eligibility and participation of the groups and individuals participating in the employer-organized association program. The department shall by July 15, 2005, promulgate administrative regulations to implement the provisions of this section and define the extent that individual information shall be provided.

(2) This section shall not require the insurer to disclose any nonpublic personal health information without the written consent of the individual who is the subject of the information, as required by administrative regulations promulgated by the commissioner. However, nonpublic personal health information may be provided to the employer-organized association health benefit plan as a covered entity to cover entity transfer under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. sec. 300gg et seq., provided that the health benefit plan certifies to the insurer that it has adopted HIPAA-required safeguards and will treat the nonpublic personal health information in accordance with HIPAA standards.

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

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group and employer-organized association markets. A basic health benefit plan shall cover physician, pharmacy, home health, preventive, emergency and in-patient and out-patient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist.

(2) An insurer that offers a basic health benefit plan shall be required to offer health benefit plans as defined in KRS 304.17A-005(19).

(3) An insurer in the individual, small group or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health

benefit plan shall include coverage for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6) and chiropractic benefits as provided in KRS 304.17A-171, and those mandated benefits specified under federal law.

(4) Not withstanding any other provisions of this section, mandated benefits excluded from coverage shall not be deemed to include the payment, indemnity, or reimbursement of specified health care providers for specific health care services.

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

An insurer that offers a basic health benefit plan shall disclose to all individuals, small employer groups and employer-organized associations prior to the issuance of a policy that the basic health benefit plan:

(1) Provides limited coverage;

(2) Includes federally mandated benefits; and

(3) Excludes state-mandated benefits, except for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6) and chiropractic benefits as provided in KRS 304.17A-171.

Section 4. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including, but not limited to, the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include those amino acid modified preparations and low-protein modified food products for the treatment of the following inherited metabolic diseases, if the amino acid modified preparations or low-protein modified food products are prescribed for therapeutic treatment and are administered under the direction of a physician, and are limited to the following conditions:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-CoA carboxylase deficiency;
8. 3-methylglutaconyl-CoA hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. Non-ketotic hyperglycinemia;
15. Propionic acidemia;
16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthetase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic aciduria;
22. Methylmalonic acidemia; and
23. Argininemia;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent;

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this

supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph;

(h) Services provided by health-care delivery networks as defined in KRS 216.900; and

(i) Services provided by midlevel health-care practitioners as defined in KRS 216.900.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

(a) Motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner or family members thereof;

(b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars ($15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or trucks shall be exempt from the fifteen thousand dollar ($15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;

(c) Salaries paid to immediate family members of the owner or administrator, or both, of a facility, to the extent that services are not actually performed and are not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

(e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health Services; and

(f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship between the facility and the supplier

exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business. An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the Cabinet for Health Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.

(5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.

(6) Nothing in this section shall be deemed to deprive a woman of all appropriate medical care necessary to prevent her physical death.

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced registered nurse practitioner licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.

(8) If payments made to community mental health centers, established pursuant to KRS Chapter 210, for services provided to the mentally retarded exceed the actual cost of providing the service, the balance of the payments shall be used solely for the provision of other services to the mentally retarded through community mental health centers.

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

(10) Family-practice physicians practicing in geographic areas with no more than one (1) primary-care physician per five thousand (5,000) population, as reported by the United States Department of Health and Human Services, shall be reimbursed one hundred twenty-five percent (125%) of the standard reimbursement rate for physician services.

(11) The Cabinet for Health Services shall make payments under the Medical Assistance program for services which are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical Assistance Program pays for the same services provided by a physician.

(12) The Medical Assistance Program shall use the form and guidelines established pursuant to subsection (5) of Section 8 of this Act for assessing the credentials of those applying for participation in the Medical Assistance Program, including those licensed and regulated under KRS Chapters 311, 312, 313, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care practitioner or facility as determined by the department through an administrative regulation promulgated under KRS Chapter 13A.

Section 5. KRS 216.2923 is amended to read as follows:

(1) For the purposes of carrying out the provisions of KRS 216.2920 to 216.2929, the secretary may:

(a) Appoint temporary volunteer advisory committees, which may include individuals and representatives of interested public or private entities or organizations;

(b) Apply for and accept any funds, property, or services from any person or government agency;

(c) Make agreements with a grantor of funds or services, including an agreement to make any study allowed or required under KRS 216.2920 to 216.2929; and

(d) Contract with a qualified, independent third party for any service necessary to carry out the provisions of KRS 216.2920 to 216.2929; however, unless permission is granted specifically by the secretary a third party hired by the secretary shall not release, publish, or otherwise use any information to which the third party has access under its contract.

(2) For the purposes of carrying out the provisions of KRS 216.2920 to 216.2929, the secretary shall:

(a) Publish and make available information that relates to the health care financing and delivery system, the cost of workers' compensation health benefits, motor vehicle health insurance benefits, and health insurance premiums and benefits that is in the public interest;

(b) Periodically participate in or conduct analyses and studies that relate to:

1. Health-care costs;

2. Health-care quality and outcomes;

3. Health-care providers and health services; ***and***

4. Health insurance costs;~~[and~~

~~5. The cost of health benefits covered by workers' compensation insurance;]~~

(c) Promulgate administrative regulations pursuant to KRS Chapter 13A that relate to its meetings, minutes, and transactions related to KRS 216.2920 to 216.2929;

(d) Prepare annually a budget proposal that includes the estimated income and proposed expenditures for the administration and operation of KRS 216.2920 to 216.2929; and

(e) No later than thirty (30) days after July 15, ***2005***~~[1998]~~, appoint and convene a permanent ***cabinet*** advisory committee***. The committee shall advise the secretary on the collection, analysis and distribution of consumer-oriented information related to the health care system, the cost of treatment and procedures, outcomes and quality indicators, and policies and regulations to implement the electronic collection and transmission of patient information (e-health) and other cost-saving patient record systems. At a minimum, the committee shall be composed of the following:***

1. Commissioner of the Department for Public Health;

2. Commissioner of the Department for Mental Health and Mental Retardation Services;

3. Commissioner of the Department for Medicaid Services;

4. Commissioner of the Department of Insurance;

5. Physician representatives;

6. Hospital representatives;

7. Health insurer representatives;

8. Consumers; and

9. Nonphysician healthcare providers.

(f) The cabinet advisory committee shall utilize the Health Services Data Advisory Committee_as a subcommittee, which shall include a member of the ***Office of Women's Physical and Mental Health***~~[Kentucky Commission on Women]~~, to define quality outcome measurements and to advise the cabinet on technical matters including proper interpretation of the data and the manner in which it should be published and disseminated to the public, state and local leaders in health policy, health facilities, and health-care providers.

(3) The cabinet may promulgate administrative regulations pursuant to KRS Chapter 13A that impose civil fines not to exceed five hundred dollars ($500) for each violation for knowingly failing to file a report as required under KRS 216.2920 to 216.2929. The amount of any fine imposed shall not be included in the allowed costs of a facility for Medicare or Medicaid reimbursement.

Section 6. KRS 216B.155 is amended to read as follows:

(1) All health care facilities and services licensed under this chapter, with the exception of personal care homes, family care homes, and boarding homes, shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems related to the quality of health care facilities and services. These standards shall be made available upon request to the public during regular business hours and shall include:

(a)~~[(1)]~~ An ongoing written internal quality assurance or improvement program;

(b)~~[(2)]~~ Specific, written guidelines for quality care studies and monitoring;

(c)~~[(3)]~~ Performance and clinical outcomes-based criteria;

(d)~~[(4)]~~ Procedures for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e)~~[(5)]~~ A plan for data gathering and assessment;

(f)~~[(6)]~~ A peer review process; and

(g)~~[(7)]~~ A summary of process outcomes and follow-up actions related to the overall quality improvement program for the health care facility or service.

Current federal or state regulations which address quality assurance and quality improvement requirements for nursing facilities, intermediate care facilities, and skilled care facilities shall suffice for compliance with the standards in this section.

(2) All health care facilities licensed, with the exception of personal care homes, family care homes, and boarding homes, under this chapter, shall use the application form and guidelines established pursuant to subsection (5) of Section 8 of this Act for assessing the credentials of those applying for privileges.

Section 7. 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) ***"Basic health benefit plan" means any plan offered to an individual, a small group or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;***

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

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

(7)~~[(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;

(8) ~~[(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;

(9) ~~[(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;

(10) ~~[(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;

(11) ~~[(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;

(12) ~~[(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;

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

(14) ~~[(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;

(15) ~~[(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;

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

(17) ~~[(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;

(18) ~~[(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;

(19) ~~[(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;

(20) ~~[(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;

(21) ~~[(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;

(22)~~[(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;

(23)~~[(22)]~~ "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan;

(24)~~[(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;

(25)~~[(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;

(26)~~[(25)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

(27)~~[(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;

(28)~~[(27)]~~ "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;

(29) ~~[(28)]~~ "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;

(30) "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

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

(32) ~~[(30)]~~ "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;

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

(34) ~~[(32)]~~ "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;

(35) ~~[(33)]~~ "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;

(36) ~~[(34)]~~ "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;

(37) ~~[(35)]~~ "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;

(38) ~~[(36)]~~ "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;

(39) ~~[(37)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

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

Section 8. KRS 304.17A-545 is amended to read as follows:

(1) A managed care plan shall appoint a medical director who:

(a) Is a physician licensed to practice in this state;

(b) Is in good standing with the State Board of Medical Licensure;

(c) Has not had his or her license revoked or suspended, under KRS 311.530 to 311.620;

(d) Shall sign any denial letter required under KRS 304.17A-540; and

(e) Shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan.

(2) The medical director shall ensure that:

(a) Any utilization management decision to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by a physician, except in the case of a health care service rendered by a chiropractor or optometrist, that decision shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky;

(b) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person or the participating provider;

(c) In the case of a managed care plan, a procedure is implemented whereby participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and whereby other participating providers have an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice;

(d) The utilization management program is available to respond to authorization requests for urgent services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonurgent health care services; and

(e) In the case of a managed care plan, a covered person is permitted to choose or change a primary care provider from among participating providers in the provider network and, when appropriate, choose a specialist from among participating network providers following an authorized referral, if required by the insurer, and subject to the ability of the specialist to accept new patients.

(3) A managed care plan shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services. These standards shall be made available to the public during regular business hours and include:

(a) An ongoing written, internal quality assurance or improvement program;

(b) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(c) Performance and clinical outcomes-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e) A plan for data gathering and assessment; and

(f) A peer review process.

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

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

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

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

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

(5) ***The commissioner shall promulgate administrative regulations to establish a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers in accordance with subsection (4) of this section. In developing a uniform application and guidelines, the department shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.***

(6) A managed care plan shall not use a health care provider beyond, or outside of, the provider's legally authorized scope of practice.

Section 9. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high risk individuals rather than using the criteria established in KRS 304.17A-005***(21)*** ~~[(20)]~~ and 304.17A-280 for high cost conditions;

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

Section 10. KRS 304.17B-001 is amended to read as follows:

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

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

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

(3) "Assessment process" means the process of assessing and allocating guaranteed acceptance program losses or Kentucky Access funding as provided for in KRS 304.17B-021;

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

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to

facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

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

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

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

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

(10) "Eligible individual" is defined in KRS 304.17A-005***(9)***~~[(7)]~~;

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

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

(13) "Health benefit plan" is defined in KRS 304.17A-005***(19)***~~[(17)]~~;

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

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

(16) "Insurer" is defined in KRS 304.17A-005***(24)***~~[(23)]~~;

(17) "Kentucky Access" means the program established in accordance with KRS 304.17B-001 to 304.17B-031;

(18) "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

(19) "Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in KRS 304.17B-003(5);

(20) "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in KRS 304.17B-003(5);

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

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

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

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

(25) "Standard health benefit plan" means a health benefit plan that meets the requirements of KRS 304.17A-250;

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

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

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

Section 11. KRS 304.17C-010 is amended to read as follows:

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

(1) "At the time of enrollment" means the same as defined in KRS 304.17A-005(2);

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

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005***(20)*** ~~[(19)]~~;

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

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

Section 12. KRS 304.18-114 is amended 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 KRS 304.18-110; and

(c) "Medicare" has the meaning provided in KRS 304.18-110.

(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 July 15, 2002, 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 KRS 304.18-110 or COBRA as defined in KRS

304.17A-005***(7)***~~[(6)]~~, 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 13. KRS 304.38A-010 is amended to read as follows:

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

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

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a a limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in KRS 304.17C-010 unless exempted by the commissioner;

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

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

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

(6) "Provider" means the same as defined in KRS 304.17A-005***(20)*** ~~[(19)]~~.

Section 14. KRS 91A.080 is amended to read as follows:

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

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

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

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

(5) Pursuant to KRS 304.3-270, if any other state retaliates against any Kentucky domiciliary insurer because of the requirements of this section, the commissioner of insurance shall

impose an equal tax upon the premiums written in this state by insurers domiciled in the other state.

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

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

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

(a) Casualty;

(b) Automobile;

(c) Inland marine;

(d) Fire and allied perils;

(e) Health; and

(f) Life.

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

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

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

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

(b) If a county imposed and collected the license fee or tax authorized by this section before July 1, 2000, then insurance companies that pay license fees or taxes under this

section shall not credit against the county license fee or tax that portion of a city license fee or tax that becomes effective for the first time on or after July 1, 2000, or is increased effective on or after July 1, 2000. The provisions of this paragraph shall expire on June 30, 2002, unless extended by the General Assembly.

(13) No license fee or tax imposed under this section shall apply to premiums received on health insurance policies issued to individuals nor to policies issued through Kentucky Access created in KRS 304.17B-005.

(14) No license fee or tax imposed under this section shall apply to premiums paid to insurers of municipal bonds, leases, or other debt instruments issued by or on behalf of a city, county, charter county government, urban-county government, consolidated local government, special district, nonprofit corporation, or other political subdivision of the Commonwealth. However, this exemption shall not apply if the bonds, leases, or other debt instruments are issued for profit or on behalf of for-profit or private organizations.

(15) No license fee or tax imposed under this section shall apply to premiums received on high deductible health plans as defined in 26 U.S.C. sec. 223(c)(2).

Section 15. In order to improve access and affordability in the small group market, an emergency is declared to exist and Section 2 of this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming law.

Approved March 18, 2005.