CHAPTER 183

(SB 209)

AN ACT relating to health insurance and declaring an emergency.

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

Section 1. KRS 304.14-500 is amended to read as follows:

For the purpose of KRS 304.14-510 to 304.14-550:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(b) In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means, for the purposes of KRS 304.14-510 to 304.14-550, any certificate issued under a group Medicare supplement policy, which policy has been delivered or issued for delivery in this state.

(3) "Medicare supplement policy" means a group or individual policy of (accident and sickness) insurance or a subscriber contract (of hospital and medical service associations ***or health maintenance organizations***) other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. secs. 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. sec. 1395***ss***(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. Such ***policy***~~[term]~~ does not include:

(a) ***Medicare Advantage plans established under Medicare Part C;***~~[A policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; or]~~

(b) ***Prescription drug plans established under Medicare Part D; or***

(c) Health care prepayment plans that provide benefits pursuant to an agreement under 42 U.S.C. sec. 1395l(a)(1)(A)~~[A policy or contract of any professional, trade, or occupational association for its members or former or retired members, or combination thereof, if such association:~~

~~1. Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;~~

~~2. Has been maintained in good faith for purposes other than obtaining insurance; and~~

~~3. Has been in existence for at least two (2) years prior to the date of its initial offering of such policy or plan to its members~~].

(4) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Section 2. 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.

(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.

(b) 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 the commissioner subsequently determines that the filing contained misrepresentations or was based on fraudulent information, and 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;

(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) 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. ***Sixty-five percent (65%)***~~[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).

(i) Notwithstanding the provisions of this subsection, an insurer may amend the policy forms used before the effective date of this Act or may amend the minimum loss ratio guarantee on policy forms filed with the department and used by the insurer prior to the effective date of this Act to provide for a minimum loss ratio guarantee allowed under this subsection for policies issued, delivered, or renewed on or after the effective date of this Act.

(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 3. In order to comply with the requirements of the Medicare Prescription Drug Improvement and Modernization Act of 2003, an emergency is declared to exist and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming law.

Approved March 31, 2005.