CHAPTER 166

(HB 284)

AN ACT relating to insurance.

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

➔Section 1. KRS 304.11-020 is amended to read as follows:

(1) Other than KRS 304.11-050, the provisions of KRS 304.11-020 to 304.11-050, shall not apply to any insurance company or underwriter issuing contracts of insurance to industrial insureds, government entity insureds, and exempt commercial policyholders, nor to any contract of insurance issued to any one (1) or more industrial insureds.

(2) For the purpose of this section:

(a) An "industrial insured" is:

1. An insured who procures the insurance of any risk or risks other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained qualified insurance consultant; and

2. An insured whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars ($25,000); and

3. An insured having at least twenty-five (25) full-time employees; and

4. All entities that have qualified as industrial insureds as of July 1, 1999.

(b) A "government entity insured" is an insured:

1. That is a government entity, municipal corporation, or public agency located in a city or county having a population of less than fifty thousand (50,000); and

2. That procures the insurance of any risk or risks, other than life and annuity contracts, by use of the services of a full-time employee acting as an insurance manager or buyer, or by the use of the services of a regularly and continuously retained qualified insurance consultant; and

3. Whose aggregate annual premiums for insurance on all risks total at least one hundred thousand dollars ($100,000), exclusive of life, health, medical, or annuity premiums; and

4. That has at least fifty (50) full-time employees; and

5. That satisfies the criteria the executive director promulgates by administrative regulation.

(c) 1. An "exempt commercial policyholder" means an insured that employs the services of an insurance agent or broker, procures commercial insurance with the services of a full-time risk manager, or a licensed insurance consultant, pursuant to Subtitle 9 of this chapter and:

a. Is a city, county, or urban-county with a population of at least fifty thousand (50,000) persons, or the Commonwealth, or a not-for-profit organization or a public entity with an annual budget of at least twenty-five million dollars ($25,000,000) or assets of at least twenty-five million dollars ($25,000,000) in the preceding fiscal year; or

b. Certifies that it meets all four (4) of the following criteria:

i. Possesses a net worth of more than twenty-five million dollars ($25,000,000) at the time the policy of insurance is issued;

ii. Generated net revenue or sales of more than fifty million dollars ($50,000,000) in the preceding fiscal year;

iii. Employs more than one hundred (100) employees per individual company or two hundred (200) employees per holding company aggregate at the time the policy of insurance is issued; and

iv. Paid annual aggregate insurance premiums of more than five hundred thousand dollars ($500,000) in the preceding fiscal year.

2. As used in this subsection, "risk manager" means a person qualified to assess an exempt commercial policyholder's insurance needs and analyze and negotiate a policy of insurance on behalf of an exempt commercial policyholder. A risk manager shall be:

a. A full-time employee of an exempt commercial policyholder who holds a professional designation relevant to the type of insurance to be purchased by the exempt commercial policyholder; or

b. A person retained by an exempt commercial policyholder who holds a professional designation relevant to the type of insurance to be purchased by the exempt commercial policyholder.

~~[(d) The requirements of this section shall not apply to a policy of insurance sold to an exempt commercial policyholder.~~

~~(e) Policies issued to an exempt commercial policyholder shall contain a disclaimer in language similar to the following: "The rate provided for in this policy is exempt from the filing and approval requirements of this section."~~

~~(f) The exemption of commercial policyholders under this section shall not apply to Subtitle 39 of this chapter, KRS Chapter 342, sections in Subtitle 13 of this chapter that pertain to workers' compensation insurance, and KRS 304.12-230.]~~

(3) ***(a)*** Policies issued to industrial insureds, government entity insureds, and exempt commercial policyholders are exempt from the rate and policy form requirements of this chapter.

(b) Policies issued to industrial insureds, government entity insureds, and exempt commercial policyholders shall contain a disclaimer in language similar to the following: "The rate provided for in this policy is exempt from the filing and approval requirements of Subtitle 13 of KRS Chapter 304. The forms which make up this policy contract are exempt from the filing and approval requirements of Subtitle 14 of KRS Chapter 304."

(c) The exemption of commercial policyholders under this section shall not apply to Subtitle 39 of this chapter, KRS Chapter 342, sections in Subtitle 13 of this chapter that pertain to workers' compensation insurance, and KRS 304.12-230.

(4) All industrial insureds, government entity insureds, and exempt commercial policyholders shall reapply to the executive director for their respective insured status every three (3) years, on a form the executive director shall promulgate by administrative regulation.

(5) KRS 304.11-020 to 304.11-050, inclusive, shall not apply to any life insurance company organized and operated, without profit to any private shareholder or individual, exclusively for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual by issuing insurance and annuity contracts directly from the home office of the company and without agents or representatives in this state only to or for the benefit of such institutions and to individuals engaged in the services of such institutions, nor to any policy or contract which it issues; but this exemption shall be conditioned upon any such company complying with the following requirements:

(a) Payment of an annual registration fee;

(b) Filing a copy of any policy or contract issued to Kentucky residents with the executive director;

(c) Filing a copy of its annual statement prepared pursuant to the laws of its state of domicile, as well as such other financial material as may be requested, with the executive director; and

(d) Providing, in such form as may be acceptable for the appointment of the Secretary of State as its true and lawful attorney upon whom may be served all lawful process in any action or proceeding against such company arising out of any policy or contract it has issued to, or which is currently held by, a Kentucky citizen and process so served against such company shall have the same force and validity as if served upon the company.

➔Section 2. KRS 304.13-053 is amended to read as follows:

(1)[~~Within sixty (60) days of December 12, 1996, the licensed workers' compensation advisory organizations shall file with the executive director an estimate of changes in prospective workers' compensation losses attributable to any net savings under 1996 (1st Extra. Sess.) Ky. Acts ch. 1. Within sixty (60) days of receipt of the workers' compensation filing, the executive director shall approve or disapprove the filing. Insurers may incorporate these approved estimates in the filings made pursuant to subsection (2) of this section.~~

~~(2) Insurers shall file workers' compensation rates incorporating an actuarially justified estimate of changes in prospective losses attributable to any net savings under 1996 (1st Extra. Sess.) Ky. Acts ch. 1 for use with workers' compensation policies issued or renewed after May 1, 1997. Workers' compensation rates shall be filed with and approved by the executive director as provided in KRS 304.13-051(2).~~

~~(3)~~] Unless the executive director enters an order pursuant to KRS 304.13-041 declaring workers' compensation to be a noncompetitive market, rates filed for use after December 31, 1998, shall be filed pursuant to KRS 304.13-051(1).

(2)[~~(4)~~] Notwithstanding the provisions of KRS 304.13-051 to the contrary, after December 31, 1998, no insurer providing workers' compensation insurance shall place into effect any rates, manuals, or underwriting rules for workers' compensation insurance which it proposes to use pursuant to KRS 304.13-051(1) or (4) if the rates, manuals, or underwriting rules will result in an increase or decrease of more than fifteen percent (15%) from the workers' compensation insurer's then-existing workers' compensation insurance rates for any classification of risks within a twelve (12) month period of time.

(3)[~~(5)~~] After December 31, 1998, any workers' compensation insurer which proposes to change its then-existing rates, manuals, or underwriting rules so as to effectively increase or decrease the rates of any classification of risks more than fifteen percent (15%) within a twelve (12) month period shall file all the rates and supplemental rating information which shall not become effective until approved by the executive director pursuant to the provisions of KRS 304.13-051.

➔Section 3. KRS 304.14-435 is amended to read as follows:

(1) All policy forms filed with the office, and any other insurance policy or claim-related information, shall be written in the English language.

(2) ***An insurer may provide applicants and insureds with a policy, application or claim-related information in a language other than English if the conditions of subsection (3) of this section have been satisfied***[~~Applications required to be filed with the office may also be filed in a language other than English~~].

(3) The non-English version of the ***policy,*** application ***or claim-related information*** shall:

(a) Be ***a certified translation of a policy, application or claim-related information that has been*** filed with ***and approved by*** the office;

(b) Be accompanied by a certification written in English that the non-English version is a complete and accurate translation of the English form filed;

(c) Be in the same format as the English version;[~~ and~~]

(d) Contain ***a disclosure, both in the non-English language and in English, that is attached to the front of the policy, application or claim-related information, including a statement indicating that:***

1. The policy, application or claim-related information is a translation that has not been approved by the office; and

2. The English version of the policy, application or claim-related information shall control in any disputes, complaints or litigation; and

(e) Identify the English form number that corresponds to the non-English version.

(4) If an insurer offers a non-English policy, application or claim-related information in accordance with subsections (2) and (3) of this section, the insurer shall file the translator certification and disclosure required by paragraph (d) of subsection (3) with the office as an information filing[~~all items in English immediately followed in parenthesis with the non-English translation~~].

(5)[~~(3)~~] This section shall not prohibit an insurer from advertising or providing information related to the policy or claims with translations to consumers in a language other than English.

(6)~~[(4)]~~ If there is a dispute between the English version and the non-English version, the English version shall control and the non-English version shall carry a disclaimer in the non-English language to this effect. The insurance policy is controlling and any advertisements or informational materials used by an insurer shall not be construed to modify or change the insurance policy.

➔Section 4. KRS 304.14-545 is amended to read as follows:

If an individually marketed~~[individual]~~ Medicare supplement insurance policy~~[issued, delivered, or renewed on or after July 12, 2006,]~~ is canceled, the insurer shall return promptly the unearned portion of any premium paid beyond the month in which the cancellation is effective.~~[Cancellation shall be without prejudice to any claim originating prior to July 12, 2006.]~~

➔Section 5. KRS 304.14-615 is amended to read as follows:

(1) The executive director shall promulgate administrative regulations that include standards for full and fair disclosure setting forth the manner, content, and require disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, pre-existing conditions, incidental benefits, lapse of insurance, termination of insurance, continuation of conversion, probationary periods, limitations, exceptions, reductions, elimination periods, premium rating practices and rating increases, requirements for replacement, recurrent conditions, and definitions of terms.

(2) A long-term care insurance policy shall not:

(a) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is covered to or replaced by a new or other form within the same insurer, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(3) (a) A long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group defined in KRS 304.14-600(5)(a), shall not use a definition of "pre-existing condition" which is more restrictive than the following: "Pre-existing condition means a condition for which medical services or treatment was recommended by, or received from, a provider of health care services within six (6) months preceding the effective date of coverage of an insured person."

(b) A long-term care insurance policy or certificate, other than a policy or certificate under a policy issued to a group as defined in KRS 304.14-600(5)(a), shall not exclude coverage for a loss or confinement which is the result of a pre-existing condition unless that loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(c) The executive director may extend the limitation periods set forth in subsection (3)(a) and (b) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(d) The definition of "pre-existing condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a pre-existing condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. A long-term care insurance policy or certificate shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection.

(4) (a) A long-term care insurance policy shall not be delivered or issued for delivery in this Commonwealth if the policy:

1. Conditions eligibility for any benefits on a prior hospitalization requirement;

2. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

3. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

(b) 1. A long-term care insurance policy containing post-confinement, post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" the limitations or conditions, including any required number of days of confinement.

2. A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

(5) The executive director may promulgate administrative regulations establishing loss ratio standards for long-term care insurance policies if a specific reference to long-term care insurance policies is contained in the administrative regulations.

(6) Long-term care insurance applicants shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in KRS 304.14-600(5)(a), the applicant is not satisfied for any reason.

(7) (a) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

1. The executive director shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of an outline of coverage.

2. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

3. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(b) The outline of coverage shall include:

1. A description of the principal benefits and coverage provided in the policy;

2. A statement of the principal exclusions, reductions, and limitations contained in the policy;

3. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

4. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

5. A description of the terms under which the policy or certificate may be returned and premium refunded; and

6. A brief description of the relationship of the cost of care and benefits.

(8) A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in this Commonwealth or a certificate subject to approval by the executive director shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(c) A statement that the group master policy determine governing contract provisions.

(9) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of any request, the insurer shall deliver the policy summary no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions, and limitations on benefits of long-term care insurance; and

(d) If applicable to the policy type, the summary shall also include:

1. A disclosure of the effects of exercising other rights under the policy;

2. A disclosure of guarantees related to long-term care ***costs*** of insurance charges; and

3. Current and projected maximum lifetime benefits.

(10) When a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder by the insurer. The report shall include:

(a) Any long-term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, due to long-term care benefits being paid out; and

(c) The amount of long-term care benefits existing or remaining.

(11) Any policy or rider advertised or marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of KRS 304.14-600 to 304.14-625.

➔Section 6. KRS 304.14-622 is amended to read as follows:

If an individually marketed individual long-term care insurance policy~~[issued, delivered, or renewed on or after July 12, 2006,]~~ is canceled, the insurer shall return promptly the unearned portion of any premium paid beyond the month in which the cancellation is effective.~~[Cancellation shall be without prejudice to any claim originating prior to July 12, 2006.]~~

➔Section 7. KRS 304.15-350 is amended to read as follows:

(1) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in KRS 304.15-320 to 304.15-340 and in KRS 304.15-342, may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions. Notwithstanding KRS ***304.15-320***~~[304.15-330]~~, additional benefits payable:

(a) In the event of death or dismemberment by accident or accidental means;

(b) In the event of total and permanent disability;

(c) As reversionary annuity or deferred reversionary annuity benefits;

(d) As term insurance benefits provided by a rider or supplemental policy provisions to which, if issued as a separate policy, KRS 304.15-310 to 304.15-360, inclusive, would not apply;

(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26), and is uniform in amount after the child's age is one (1);

(f) As other policy benefits additional to life insurance and endowment benefits;

and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by KRS 304.15-310 to 304.15-360, inclusive, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(2) Contrary provisions. Any condition or stipulation in the policy of insurance or elsewhere contrary to the provisions of KRS 304.15-310 to 304.15-360, and any waiver of such provisions by the insured, shall be void.

➔Section 8. KRS 304.15-717 is amended to read as follows:

(1) It is unlawful for any person:

(a) To knowingly or intentionally enter into a life settlement contract when the subject life insurance policy was obtained by means of a false, deceptive, or misleading application for the life insurance policy;

(b) To knowingly or intentionally interfere with the enforcement of the provisions of this subtitle or investigations of suspected or actual violations of this subtitle;

(c) To knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements as defined in KRS 304.15-020(5);

(d) To commit a fraudulent life settlement act;

(e) To misrepresent that the life settlement provider, life settlement broker, other licensee, or any other person has been guaranteed, sponsored, recommended, or approved by the state, or by any local, state, or federal agency or officer thereof;

(f) To act as a life settlement broker if the person is acting as a life settlement provider in the same life settlement contract;

(g) For any person to pay any compensation or provide anything of value to an insured's physician, attorney, accountant, or any other person who provides medical, legal, or financial advice to the insured as a finder's or referral fee;

(h) To engage in any transaction, practice, or course of business if such person knows or reasonably should have known that the intent was to avoid the notice requirements of KRS 304.15-020 and 304.15-700 to 304.15-720;

(i) To engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state;

(j) To issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the sole purpose of or with a primary emphasis on settling the policy;

(k) To enter into a life settlement contact on a policy that was the subject of a premium finance agreement as described in KRS 304.15-020(17)(b)2.;

(l) With respect to any life settlement contract or life insurance policy and a broker, to knowingly solicit an offer from, effectuate a life settlement contract with or make a sale to any provider, financing entity, or related provider trust, or any insurer that is controlling, controlled by, or under common control with such broker unless disclosed to the owner;

(m) With respect to any life settlement contract or life insurance policy and a provider, to knowingly enter into a life settlement contract with an owner if, in connection with such life settlement contract, anything of value will be paid to a broker or provider that is controlling, controlled by, or under common control with such provider, the financing entity, or related provider trust that is involved in such life settlement, or any insurer unless disclosed to the owner;

(n) With respect to a provider, to enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by administrative regulation, have been filed with the executive director. Marketing materials shall not expressly reference that the insurance is "free" for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of KRS 304.15-700 to 304.15-720;

(o) With respect to any insurance company, insurance producer, broker, or provider, or any other person, to make any statement or representation to the applicant or policyholder in connection with the sale or

financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy; or

(p) If an insurer, to:

1. Engage in or permit any discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any life insurance policy or annuity contract based upon an individual's having entered into a life settlement contract or being insured under a settled policy;

2. Make any false or misleading statement as to the business of life settlements or financing premiums due for a policy or to any owner or insured for the purpose of inducing or tending to induce the owner or insured not to enter into a life settlement contract; or

3. Engage in any transaction, act, practice, or course of business, or dealing which restricts, limits, or impairs in any way the lawful transfer of ownership, change of beneficiary, or assignment of a policy.

This subsection shall not prohibit a statement that the person is licensed, if that statement is true and the effect of the statement is not misrepresented.

(2) A life settlement contract and an application for a life settlement contract, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and upon conviction may be subject to fines or confinement in prison, or both."

The lack of a statement required by this section does not constitute a defense in any prosecution for a fraudulent life settlement act.

(3) (a) A person engaged in the business of life settlements who has knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed shall provide the information required to the executive director, in a manner prescribed by the executive director.

(b) Any person who has knowledge or a reasonable belief that a fraudulent life settlement act is being, will be, or has been committed may provide the information required to the executive director, in a manner prescribed by the executive director in administrative regulations.

(4) (a) Civil liability may not be imposed on and a cause of action may not arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent life settlement acts, or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

1. The executive director or the executive director's employees, agents, or representatives;

2. Federal, state, or local law enforcement or regulatory officials, or their employees, agents, or representatives;

3. A person involved in the prevention and detection of fraudulent life settlement acts or that person's agents, employees, or representatives;

4. The National Association of Insurance Commissioners (NAIC), the National Association of Securities Dealers (NASD), the North American Securities Administrators Association (NASAA), or their employees, agents, or representatives, or any other regulatory body overseeing life insurance or life settlement contracts;

5. The insurer that issued the policy covering the life of the insured; or

6. The licensee and any agents, employees, or representatives.

(b) This subsection shall not apply to a statement made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent life settlement act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that this subsection shall not apply because the person filing the report or furnishing the information did so with actual malice.

(c) A person who furnishes information concerning fraudulent life settlement acts and who is a party in a civil cause of action for libel, slander, or another relevant tort arising out of activities in carrying out the provisions of this chapter shall be entitled to an award of attorney's fees and court costs if he is the prevailing party in the suit and the party bringing the action was not substantially justified in filing the cause of action. For purposes of this paragraph, a proceeding is "substantially justified" if a person had a reasonable basis in law or fact at the time the cause of action was initiated.

(d) This subsection shall not abrogate or modify common law or statutory privileges or immunities enjoyed by a person.

(e) This subsection shall not apply to a person who furnishes information concerning his own suspected, anticipated, or completed fraudulent life settlement acts or suspected, anticipated, or completed fraudulent insurance acts.

(5) The documents and evidence provided pursuant to subsection (4) of this section or obtained by the executive director in an investigation of suspected or actual fraudulent life settlement acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action, except that:

(a) This subsection shall not prohibit release by the executive director of documents and evidence obtained in an investigation of suspected or actual fraudulent life settlement acts:

1. In administrative or judicial proceedings to enforce laws administered by the executive director;

2. To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent life settlement acts, or to the National Association of Insurance Commissioners (NAIC); or

3. At the discretion of the executive director, to a person in the business of life settlements that is aggrieved by a fraudulent life settlement act.

(b) The release of documents and evidence provided by paragraph (a) of this subsection shall not abrogate or modify the privilege granted by this subsection.

(6) This section shall not:

(a) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(b) Prevent or prohibit a person from voluntarily disclosing information concerning fraudulent life settlement acts to a law enforcement or regulatory agency other than the Office of Insurance;

(c) Limit the powers granted elsewhere by the laws of this state to the executive director or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers; or

(d) Preempt, supersede, or limit any provision of any state securities law or any rule, order, administrative regulation, or notice issued thereunder.

(7) A life settlement provider shall adopt antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent life settlement acts. The executive director may order or, if a licensee requests, may grant modifications of the required initiatives listed in this subsection as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications reasonably may be expected to accomplish the purpose of this section. Antifraud initiatives shall include the following:

(a) Fraud investigators, who may be life settlement providers or employees or independent contractors of those life settlement providers; and

(b) An antifraud plan ***that shall be filed with*** ~~[submitted to]~~ the executive director ***and*** that shall include but is not limited to the following:

1. The procedures for detecting and investigating possible fraudulent life settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

2. The procedures for reporting possible fraudulent life settlement acts to the executive director;

3. The plan for antifraud education and training of underwriters and other personnel; and

4. A chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible fraudulent life settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

Antifraud plans ***filed with*** ~~[submitted to]~~ the executive director shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

➔Section 9. KRS 304.17-415 is amended to read as follows:

If an individually marketed ~~[individual]~~ health insurance policy ~~[issued, delivered, or renewed on or after July 12, 2006,]~~ is canceled, the insurer shall return promptly the unearned portion of any premium paid beyond the month in which the cancellation is effective. ~~[Cancellation shall be without prejudice to any claim originating prior to July 12, 2006.]~~

➔Section 10. KRS 304.33-430 is amended to read as follows:

The order of distribution of claims from the insurer's estate shall be as stated in this section. The first fifty dollars ($50) of the amount allowed on each claim in the classes under subsections (3) to (7), inclusive, of this section, shall be deducted from the claim and included in the class under subsection (9) of this section. Claims may not be cumulated by assignment to avoid application of the fifty dollars ($50) deductible provision. Subject to the fifty dollars ($50) deductible provision, every claim in each class shall be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. No subclasses shall be established within any class. No claim by a shareholder, policyholder, or other creditor shall be permitted to circumvent the priority classes through the use of equitable remedies.

(1) Administration costs. The costs and expenses of administration, including but not limited to the following: the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; and reasonable attorney's fees.

(2) Health maintenance organization and limited health service organization out-of-network claims. In a liquidation of a health maintenance organization or limited health service organization, any claims for health plan benefits or for limited health service contract benefits for out-of-network claims that would have otherwise been covered.

(3) Loss and unearned premium claims. Claims by policyholders, beneficiaries, and insureds arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and liability claims against insureds which claims are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and claims of guaranty associations or foreign guaranty associations. Notwithstanding the foregoing, the following claims shall be excluded from Class 2 priority:

(a) Obligations of the insolvent insurer arising out of reinsurance contracts;

(b) Obligations incurred after the expiration date of the insurance policy or after the policy has been replaced by the insured or canceled at the insured's request or after the policy has been canceled as provided in this chapter. Notwithstanding this subsection, earned premium claims on policies, other than reinsurance agreements, shall not be excluded;

(c) Obligations to insurers, insurance pools, or underwriting associations and their claims for contribution, indemnity, or subrogation, equitable or otherwise;

(d) Any claim which is in excess of any applicable limits provided in the insurance policy issued by the insolvent insurer;

(e) Any amount accrued as punitive or exemplary damages unless expressly covered under the terms of the policy; and

(f) Tort claims of any kind against the insurer, and claims against the insurer for bad faith or wrongful settlement practices.

(4) Claims of the federal government other than those claims included in Class 2.

(5) Wages.

(a) Debts due to employees for services performed, not to exceed one thousand dollars ($1,000) to each employee which have been earned within one (1) year before the filing of the petition for liquidation. Officers shall not be entitled to the benefit of this priority.

(b) This priority shall be in lieu of any other similar priority authorized by law as to wages or compensation of employees.

(6) Residual classification. All other claims including claims of the federal or any state or local government, not falling within other classes under this section. Claims, including those of any governmental body, for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (9) of this section.

(7) Judgments. Claims based solely on judgments. If a claimant files a claim and bases it both on the judgment and on the underlying facts, the claim shall be considered by the liquidator who shall give the judgment such weight as he deems appropriate. The claim as allowed shall receive the priority it would receive in the absence of the judgment. If the judgment is larger than the allowance on the underlying claim, the remaining portion of the judgment shall be treated as if it were a claim based solely on a judgment.

(8) Interest on claims already paid. Interest at the legal rate compounded annually on all claims in the classes under subsections (1) to (7) of this section, inclusive, from the date of the petition for liquidation or the date on which the claim becomes due, whichever is later, until the date on which the dividend is declared. The liquidator, with the approval of the court, may make reasonable classifications of claims for purposes of computing interest, may make approximate computations, and may ignore certain classifications and time periods as de minimis.

(9) Miscellaneous subordinated claims. The remaining claims or portions of claims not already paid, with interest as in subsection (8) of this section:

(a) The first fifty dollars ($50) of each claim in the classes under subsections ***(3)***~~[(2)]~~ to (7), inclusive, of this section, subordinated under this section;

(b) Claims under subsection (2) of KRS 304.33-380;

(c) Claims subordinated by KRS 304.33-600;

(d) Claims filed late;

(e) Portions of claims subordinated under subsection (6) of this section; and

(f) Claims or portions of claims, payment of which is provided by other benefits or advantages recovered or recoverable by the claimant.

(10) Preferred ownership claims. Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Interest at the legal rate shall be added to each claim, as in subsections (8) and (9) of this section.

(11) Proprietary claims. The claims of shareholders or other owners.

➔Section 11. KRS 304.39-060 is amended to read as follows:

(1) Any person who registers, operates, maintains or uses a motor vehicle on the public roadways of this Commonwealth shall, as a condition of such registration, operation, maintenance or use of such motor vehicle and use of the public roadways, be deemed to have accepted the provisions of this subtitle, and in particular those provisions which are contained in this section.

(2) (a) Tort liability with respect to accidents occurring in this Commonwealth and arising from the ownership, maintenance, or use of a motor vehicle is "abolished" for damages because of bodily injury, sickness or disease to the extent the basic reparation benefits provided in this subtitle are payable therefor, or that would be payable but for any deductible authorized by this subtitle, under any insurance policy or other

method of security complying with the requirements of this subtitle, except to the extent noneconomic detriment qualifies under paragraph (b) of this subsection.

(b) In any action of tort brought against the owner, registrant, operator or occupant of a motor vehicle with respect to which security has been provided as required in this subtitle, or against any person or organization legally responsible for his acts or omissions, a plaintiff may recover damages in tort for pain, suffering, mental anguish and inconvenience because of bodily injury, sickness or disease arising out of the ownership, maintenance, operation or use of such motor vehicle only in the event that the benefits which are payable for such injury as "medical expense" or which would be payable but for any exclusion or deductible authorized by this subtitle exceed one thousand dollars ($1,000), or the injury or disease consists in whole or in part of permanent disfigurement, a fracture to a bone, a compound, comminuted, displaced or compressed fracture, loss of a body member, permanent injury within reasonable medical probability, permanent loss of bodily function or death. Any person who is entitled to receive free medical and surgical benefits shall be deemed in compliance with the requirements of this subsection upon a showing that the medical treatment received has an equivalent value of at least one thousand dollars ($1,000).

(c) Tort liability is not so limited for injury to a person who is not an owner, operator, maintainer or user of a motor vehicle within subsection (1) of this section, nor for injury to the passenger of a motorcycle arising out of the maintenance or use of such motorcycle.

(3) For purposes of this section and the provisions on reparation obligor's rights of reimbursement, subrogation, and indemnity, a person does not intentionally cause harm merely because his act or failure to act is intentional or done with his realization that it creates a grave risk of harm.

(4) Any person may refuse to consent to the limitations of his tort rights and liabilities as contained in this section. Such rejection must be ***completed*** in writing ***or electronically*** in a form to be prescribed by the Office of Insurance and must have been executed and filed with the office at a time prior to any motor vehicle accident for which such rejection is to apply.~~[Such rejection form together with a reasonable explanation thereof shall be furnished by the reparation obligor with each policy to each prospective insurance applicant.]~~ Such rejection form shall affirmatively state in bold print that acceptance of this form of insurance denies the applicant the right to sue a negligent motorist unless certain requirements contained in the policy of insurance are met. Rejection by a person who is under legal disability shall be made on behalf of such person by his legal guardian, conservator or his natural parent. The failure of such guardian or a natural parent of a person under legal disability to file a rejection, within six (6) months from the date that this subtitle would otherwise become applicable to such person, shall be deemed to be an affirmative acceptance of all provisions of this subtitle. Provided, however, any person who, at the time of an accident, does not have basic reparation insurance but has not formally rejected such limitations of his tort rights and liabilities and has at such time in effect security equivalent to that required by KRS 304.39-110 shall be deemed to have fully rejected such limitations within meaning of this section for that accident only.

(5) (a) Any rejection must be filed with the Office of Insurance and shall become effective on the date of its filing until revoked***. Nothing in this section shall require a new rejection to be filed for each new motor vehicle policy issued***;

(b) Any rejection filed prior to June 30, 1980, shall be deemed to be effective from the date of its filing until revoked; and

(c) Any revocation shall be in writing and shall become effective upon the date of its filing with the Office of Insurance.

(6) Every insurance company when issuing an automobile policy to a resident of this Commonwealth must inform the buyer in writing in a form to be prescribed by the insurance executive director of his right to reject the limitations of his tort rights and liabilities under this subtitle in the manner provided in subsections (4) and (7) of this section.

(7) Any rejection shall result in the full retention by the individual of his tort rights and his tort liabilities. Any person injured by a motor vehicle operator who has such rejection on file may claim his full damages, including nonpecuniary damages, or, if such injured person has not rejected his own tort limitations, he may also claim basic reparation benefits from the appropriate security on the vehicle as established under KRS 304.39-050. If such provider of security is other than the one providing security for the operator who has

rejected the limitations, such provider shall be subrogated to the rights of the injured person to the extent of reparation benefits paid against the owner and operator of the vehicle.

(8) No person who has rejected the tort limitations under this section, except as provided in subsection (9) of this section or KRS 304.39-140(5), may collect basic reparation benefits.

(9) Any owner or operator of a motorcycle, as defined in Kentucky Revised Statutes, may file a rejection as described in subsections (4) and (5) of this section, which will apply solely to the ownership and operation of a motorcycle but will not apply to injury resulting from the ownership, operation or use of any other type of motor vehicle.

➔Section 12. KRS 304.40-075 is amended to read as follows:

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

(a) "Charitable health care provider" means any person, agency, clinic, or facility licensed or certified by the Commonwealth, or under a comparable provision of law of another state, territory, district, or possession of the United States, engaged in the rendering of medical care or dentistry without compensation or charge, and without expectation of compensation or charge, to the individual, without payment or reimbursement by any governmental agency or insurer. "Charitable health care provider" means those persons, agencies, clinics, or facilities providing primary care medicine and performing no invasive or surgical procedures, and those persons, agencies, clinics, or facilities providing services within the dentist's scope of practice under KRS Chapter 313;

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

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

(2) Insurers offering medical professional liability insurance in the Commonwealth shall make available, as a condition of doing business in the Commonwealth pursuant to this chapter, medical professional liability insurance for charitable health care providers and persons volunteering to perform medical services for charitable health care providers, with the same coverage limits made available to its other insureds.

(3) (a) Premiums for policies issued under subsection (2) of this section shall be paid by the Commonwealth from the general fund upon written application for payment of the premium by the health care provider wishing to offer charitable services. ***A health care provider shall submit an application for payment of premium to the Office of Insurance no later than one (1) year from the expiration of the policy for which payment is being requested.***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

➔Section 13. KRS 304.45-050 is amended to read as follows:

Any purchasing group meeting the criteria established under the provisions of the Liability Risk Retention Act, 15 U.S.C. secs. 3901 et seq., shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, the countersignature requirement as provided in KRS ***304.3-240***~~[304.3-250]~~, prohibition of group purchasing of insurance, or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing, or offering to provide, to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group shall be subject to all other applicable laws of this state.

➔Section 14. KRS 304.47-020 is amended to read as follows:

(1) For the purposes of this subtitle, a person or entity commits a "fraudulent insurance act" if he or she engages in any of the following, including but not limited to matters relating to workers' compensation:

(a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Board of Claims, Special Fund, or any agent thereof, any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or from a "self-insurer" as defined by KRS Chapter 342, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(b) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Board of Claims, or any agent thereof, any statement as part of, or in support of, an application for an insurance policy, for renewal, reinstatement, or replacement of insurance, or in support of an application to a lender for money to pay a premium, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the application;

(c) Knowingly and willfully transacts any contract, agreement, or instrument which violates this title;

(d) Knowingly and with intent to defraud or deceive, receives money for the purpose of purchasing insurance, and fails to obtain insurance;

(e) Knowingly and with intent to defraud or deceive, fails to make payment or disposition of money or voucher as defined in KRS 304.17A-750, as required by agreement or legal obligation, that comes into his or her possession while acting as a licensee under this chapter;

(f) Issues or knowingly presents fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, insurance binders, or any other documents that purport to evidence insurance;

(g) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer;

(h) Engages in unauthorized insurance, as defined in KRS 304.11-030;

(i) Knowingly and with intent to defraud or deceive, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or to the executive director, any statement, knowing that the statement contains any false, incomplete, or misleading information concerning any material fact or thing, as part of, or in support of one (1) or more of the following:

1. The rating of an insurance policy;

2. The financial condition of an insurer;

3. The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance in all or part of this Commonwealth by an insurer; or

4. A document filed with the executive director;

(j) Knowingly and with intent to defraud or deceive, engages in any of the following:

1. Solicitation or acceptance of new or renewal insurance risks on behalf of an insolvent insurer; or

2. Removal, concealment, alteration, tampering, or destruction of money, records, or any other property or assets of an insurer; or

(k) Assists, abets, solicits, or conspires with another to commit a fraudulent insurance act in violation of this subtitle.

(2) (a) Except as provided in paragraphs (b) and (c) of this subsection, a person convicted of a violation of subsection (1) of this section shall be guilty of a misdemeanor where the aggregate of the claim, benefit, or money referred to in subsection (1) of this section is less than or equal to ***five hundred dollars ($500)***~~[three hundred dollars ($300)]~~, and shall be punished by:

1. Imprisonment for not more than one (1) year;

2. A fine, per occurrence, of not more than one thousand dollars ($1,000) per individual nor five thousand dollars ($5,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or

3. Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph.

(b) Except as provided in paragraph (c) of this subsection, where the claim, benefit, or money referred to in subsection (1) of this section exceeds an aggregate of ***five hundred dollars ($500)***~~[three hundred dollars ($300)]~~, a person convicted of a violation of subsection (1) of this section shall be guilty of a felony and shall be punished by:

1. Imprisonment for not less than one (1) nor more than five (5) years;

2. A fine, per occurrence, of not more than ten thousand dollars ($10,000) per individual nor one hundred thousand dollars ($100,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or

3. Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph.

(c) Any person, with the purpose to establish or maintain a criminal syndicate, or to facilitate any of its activities, as set forth in KRS 506.120(1), shall be guilty of engaging in organized crime, a Class B felony, and shall be punished by:

1. Imprisonment for not less than ten (10) years nor more than twenty (20) years;

2. A fine, per occurrence, of not more than ten thousand dollars ($10,000) per individual nor one hundred thousand dollars ($100,000) per corporation, or twice the amount of gain received as a result of the violation; whichever is greater; or

3. Both imprisonment and a fine, as set forth in subparagraphs 1. and 2. of this paragraph.

(d) In addition to imprisonment, the assessment of a fine, or both, a person convicted of a violation of paragraph (a), (b), or (c) of subsection (2) of this section may be ordered to make restitution to any victim who suffered a monetary loss due to any actions by that person which resulted in the adjudication of guilt, and to the division for the cost of any investigation. The amount of restitution shall equal the monetary value of the actual loss or twice the amount of gain received as a result of the violation, whichever is greater.

(3) Any person damaged as a result of a violation of any provision of this section when there has been a criminal adjudication of guilt shall have a cause of action to recover compensatory damages, plus all reasonable investigation and litigation expenses, including attorneys' fees, at the trial and appellate courts.

(4) The provisions of this section shall also apply to any agent, unauthorized insurer or its agents or representatives, or surplus lines carrier who, with intent, injures, defrauds, or deceives any claimant with regard to any claim. The claimant shall have the right to recover the damages provided in subsection (3) of this section.

➔Section 15. KRS 342.817 is amended to read as follows:

(1) The authority, through its board and manager, shall establish separate rating plans, rates, and underwriting standards for different classes of risks for the authority.

(2) The rating plans, rates, and underwriting standards developed for the categories of risk shall be based on generally-accepted actuarial practices and procedures as set forth in the Statement of Principles Regarding Property and Casualty Ratemaking of the Casualty Actuarial Society, in accordance with the actuarial standards of practice and compliance guidelines of the Actuarial Standards Board. The rates shall be actuarially sound for both the voluntary market and the market of last resort and set at levels which are expected, in the aggregate, to be sufficient to pay all workers' compensation claims incurred by the participating employer risks and other permitted expenses of the authority. ***The rates for the voluntary market and the market of last resort shall be filed individually with the executive director of the Office of Insurance on forms prescribed by the executive director by the promulgation of administrative regulations.***

(3) Multitiered premium or rating plans may be developed to provide workers' compensation coverage to insureds in the Commonwealth.

(4) The manager shall develop statistical and other information as necessary to distinguish its writings in the voluntary market, and its writings as a market of last resort.

(5) The rates established by the authority for its policyholders shall be based only on Kentucky loss experience data, except that other loss experience data may be utilized as a supplement to Kentucky data if supplemental or additional data are necessary to establish statistical credibility of an employment classification.

(6) Any and all rates, whether for the voluntary market or the market of last resort, established by the board are deemed competitive and shall be filed with the executive director of insurance in accordance with KRS Chapter 304 in the same manner as any other mutual insurance company writing workers' compensation in the Commonwealth.

(7) Notwithstanding any provision of KRS Chapter 304 to the contrary, the surplus requirements for mutual insurance companies in the Commonwealth shall not apply to the authority until the authority has been in operation for eighty-four (84) months, unless modified by the General Assembly. In addition to other reporting requirements in KRS 342.809 and 342.821, the authority shall report to the Labor and Industry Committee of the General Assembly, no later than October 31 of each year, on the status of its efforts to build and maintain a surplus as required by KRS Chapter 304.

➔Section 16. The following KRS section is repealed:

304.17A-071 Discontinuance of operation of Kentucky Health Purchasing Alliance -- Executive director to terminate alliance activities by June 30, 1999.

Signed by Governor April 26, 2010.