

**CHAPTER 45**  
**( HB 527 )**

AN ACT relating to insurance regulatory requirements and declaring an emergency.

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

➔Section 1. KRS 304.1-050 is amended to read as follows:

*As used in this chapter, unless the context requires otherwise:*

- (1) "Commissioner" means the commissioner of the Department of Insurance of this state; ~~and~~;
- (2) "Department" means the Department of Insurance of this state, ~~unless context otherwise requires~~.

➔Section 2. KRS 304.1-110 is amended to read as follows:

*As used in this chapter, unless the context requires otherwise:*

- (1) ~~["Certificate of authority" means a certificate~~ ~~is one~~ issued by the commissioner evidencing the authority of an insurer to transact insurance in this state; ~~and~~;
- (2) ~~["License" means a license or other authorization~~ ~~is authority~~ granted by the commissioner pursuant to this ~~chapter that authorizes~~ ~~code authorizing~~ the licensee to engage in a business or operation of insurance in this state other than as an insurer, ~~and the certificate by which such authority is evidenced~~.

➔Section 3. KRS 304.2-160 is amended to read as follows:

- (1) *As used in this section, "licensee" means an individual or entity that holds a license issued by the commissioner or department.*
- (2) Each written and signed complaint received by the department ~~of Insurance~~ shall be recorded by the department, including the subsequent disposition thereof, and maintained for a period of not less than five (5) years.
- (3) The records of ~~such~~ complaints *received by the department* shall be indexed whenever applicable both by the name of the insurer and by the name of the licensee ~~, including agent, surplus lines broker, adjuster, administrator, reinsurance intermediary broker or manager, rental vehicle agent or managing employee, specialty credit producer or managing employee, life settlement broker or provider, or consultant~~ involved.
- (4) The commissioner shall consider ~~such~~ complaints *received by the department* before issuing or renewing any certificate of authority or license.

➔Section 4. KRS 304.2-220 is amended to read as follows:

For the purpose of ascertaining compliance with law, or relationships and transactions between any person and any insurer or proposed insurer, the commissioner may as often as reasonably necessary examine the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs or proposed insurance affairs and transactions of *any*:

- (1) ~~Any~~ Insurance holding company; ~~or~~
- (2) Person holding the shares of voting stock or policyholder proxies of an insurer as voting trustee or otherwise, for the purpose of controlling the management thereof;
- ~~(3)~~(2) ~~Any~~ Insurance agent, *managing general agent*, surplus lines broker, adjuster, consultant, administrator, reinsurance intermediary broker or manager, rental vehicle agent, ~~or~~ *rental vehicle agent* managing employee, *pharmacy benefit manager, portable electronics retailer* ~~specialty credit producer or managing employee~~, or any person holding himself or herself out as any of the foregoing;
- ~~(4)~~(3) ~~Any~~ Person having a contract under which he or she enjoys by terms or in fact the exclusive or dominant right to manage or control ~~an~~ ~~the~~ insurer, as voting trustee, ~~or~~ otherwise; and
- ~~(5)~~(4) ~~Any~~ Person in this state engaged in, ~~or~~ proposing to be engaged in ~~this state in~~, ~~or~~ holding himself or herself out ~~in this state~~ as so engaging or proposing, or ~~in this state~~ assisting in the promotion, formation, or financing of:

- (a) An insurer;~~[-or]~~
- (b) An insurance holding *company*;~~[-corporation,]~~ or
- (c) A corporation or other group to finance an insurer or the production of its business.

➔Section 5. KRS 304.2-450 is amended to read as follows:

- (1) As used in this section:
  - (a) "Insurable dwelling":
    - 1. Means a dwelling located or situated on, or affixed to, residential real estate; and
    - 2. Includes a single-family or multifamily dwelling, including a modular home;~~[-and]~~
  - (b) ***"SKH approved contractor" means a person that has been determined by the commissioner pursuant to an administrative regulation promulgated in accordance with subsection (5) of this section to be eligible and approved to mitigate insurable dwellings under the Strengthen Kentucky Homes Program;***
  - (c) ***"SKH online portal" means an online portal through which a person seeking to become an SKH approved contractor is required to submit documents to the department pursuant to an administrative regulation promulgated in accordance with subsection (5) of this section; and***
  - (d) "Strengthen Kentucky Homes Program" or "program" means the Strengthen Kentucky Homes Program created in this section.
- (2) The Strengthen Kentucky Homes Program is hereby created for the purpose of providing financial grants to real property owners, ***SKH approved***~~[building]~~ contractors, and nonprofit organizations to assist and promote the mitigation of insurable dwellings to resist losses due to catastrophic wind and hail events in accordance with FORTIFIED construction standards published by the Insurance Institute for Business and Home Safety or a successor entity.
- (3) To the extent funding is available under subsection (4) of this section, the commissioner shall implement and administer the program in accordance with this section.
- (4)
  - (a) The Strengthen Kentucky Homes Program fund is hereby created in the State Treasury.
  - (b) The following shall be deposited into the fund:
    - 1. All grants and funds received or raised by the commissioner under paragraph (e) of this subsection; and
    - 2. Any appropriations made to the fund by the General Assembly.
  - (c) Notwithstanding KRS 45.229:
    - 1. Moneys in the fund not expended at the close of a fiscal year shall not lapse but shall be carried forward to the next fiscal year; and
    - 2. Any interest earnings of the fund shall become part of the fund and shall not lapse.
  - (d) Moneys in the fund are hereby appropriated by the General Assembly and shall be available to the commissioner for use in implementing and administering the program, ***except the commissioner shall not make financial grants under subsection (7) of this section that exceed, in aggregate, fifteen thousand dollars (\$15,000).***
  - (e) The commissioner shall use his or her best efforts to seek and obtain grants or funds from the federal government or other funding sources for deposit into the fund to supplement any appropriations to the fund made by the General Assembly.
- (5)
  - (a) ***Except as provided in subsection (7) of this section,*** the commissioner shall promulgate administrative regulations in accordance with KRS Chapter 13A to create and establish:
    - 1. Application forms and procedures for seeking a financial grant;
    - 2. The eligibility criteria, requirements, and procedures for obtaining a financial grant, which may include but are not limited to providing financial grants to:
      - a. Real property owners to mitigate owner-occupied insurable dwellings; ***and***

- b. ~~[Building contractors to become certified as FORTIFIED Trained Service Providers by the Insurance Institute for Business and Home Safety or a successor entity; and~~
  - e. ~~[Nonprofit organizations to improve the wind and hail resilience of single-family insurable dwellings occupied or owned by low-income and moderate-income individuals;~~
3. If the commissioner provides financial grants to mitigate insurable dwellings:
    - a. i. The building standards or techniques that are required for the mitigation, which shall include but are not limited to compliance with the most recent version of any applicable FORTIFIED Home or FORTIFIED Multifamily construction standards published by the Insurance Institute for Business and Home Safety or a successor entity.
    - ii. The commissioner shall determine through the promulgation of an administrative regulation under this subsection the specific standards and designations that are required for any insurable dwelling; and
    - b. Eligibility criteria for building contractors and evaluators that are eligible to mitigate and inspect the insurable dwellings, respectively, which shall include a preference for Kentucky building contractors and evaluators; and
  4. The procedures and requirements for distributing financial grants.
- (b) The commissioner may promulgate administrative regulations in accordance with KRS Chapter 13A to establish any additional rules and eligibility requirements that are necessary for the proper implementation and administration of this section, including but not limited to the collection of documentation necessary to allow for any auditing of the program that is required under the terms of a grant or other funds received by the program.
- (6) Any financial grant provided under the program to mitigate an insurable dwelling shall be contingent upon the real property owner securing all required permits and applicable inspections in accordance with local building codes.
- (7) (a) *The commissioner shall make one (1) time financial grants in accordance with this subsection to SKH approved contractors to reimburse each contractor for the cost of an initial certification by the Insurance Institute for Business and Home Safety or a successor entity to act as a CERTIFIED Roofing contractor.*
- (b) *In order to receive reimbursement under this subsection, an SKH approved contractor shall upload the following documents through the SKH online portal:*
1. *A request for reimbursement under this subsection; and*
  2. *A receipt or other documentation from the Insurance Institute for Business and Home Safety or a successor entity that states:*
    - a. *The contractor's name and address, which shall match the name and address that is on file with the department;*
    - b. *That the contractor is certified to act as a CERTIFIED Roofing contractor;*
    - c. *The date the receipt or other documentation was issued; and*
    - d. *The cost paid for the certification referenced in subdivision b. of this subparagraph.*
- (c) *Upon compliance with paragraph (b) of this subsection by an SKH approved contractor, the commissioner shall, to the extent funding is available under subsection (4) of this section, make a one (1) time financial grant to the contractor in the amount of the cost paid for the certification.*
- (d) *Financial grants made under this subsection shall be made to SKH approved contractors in the order that the contractors satisfy the requirements of paragraph (b) of this subsection.*
- (e) *Checks shall be mailed to the address of the contractor's choice.*
- (f) *The commissioner shall not be required to establish additional forms, procedures, or requirements, by administrative regulation or otherwise, in order to implement, or distribute financial grants under, this subsection.*

- (8) Nothing in this section shall be construed to create an entitlement for property owners, *SKH approved*~~(building)~~ contractors, or nonprofit organizations to obtain funds for, or obligate the state in any way to fund, *or maintain funding for*, any activity for which a financial grant is permitted *or provided* under this section.

➔Section 6. KRS 304.4-040 is amended to read as follows:

- (1) *As used in this section, "licensee" means an individual or entity that holds a license issued by the commissioner or department.*
- (2) The commissioner may revoke the certificate of authority of any insurer which fails to pay when due any taxes, fees, licenses, and other charges owing to this state. The commissioner may likewise revoke the license of any *licensee*~~[agent, surplus lines broker, adjuster, administrator, reinsurance intermediary broker or manager, rental vehicle agent or managing employee, specialty credit producer or managing employee, life settlement broker or provider, or consultant,]~~ as to whom any tax or fee required under this *chapter*~~[code]~~ has not been paid when due.

➔Section 7. KRS 304.5-080 is amended to read as follows:

- (1) *As used in this chapter, "inland marine insurance" means marine and transportation insurance that may cover or include*~~["Marine and transportation insurance" includes]:~~
- (a) *1. Imports, wherever the property may be and without restriction as to time, if the coverage includes hazards of transportation.*
- 2. An import, as a proper subject of marine and transportation insurance, shall be deemed to:*
- a. Maintain its character if the property:*
- i. Remains segregated in such a way that it can be identified; and*
- ii. Has not become incorporated and mixed with the general mass of property in the United States; and*
- b. Have been completed when the property has been:*
- i. Sold and delivered by the importer, factor, or consignee;*
- ii. Removed from place of storage and placed on sale as part of an importer's stock in trade at a point of sale or distribution; or*
- iii. Delivered for manufacture, processing, or change in form to premises of the importer or of another used for any such purposes;*~~[Insurance against any kinds of loss or damage to:~~
- ~~1. Vessels, craft, aircraft, goods, freights, cargoes, merchandise, effects, disbursements, profits, moneys, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to, or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting the same or during any delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks, and~~
- ~~2. Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of such insurance (but not including life insurance or surety bonds nor insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles), and~~
- ~~3. Precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether the same be in course of transportation or otherwise, and~~
- ~~4. Bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage), unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered; piers, wharves, docks and slips, excluding the risks of fire, tornado,~~

~~sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks. }~~

- (b) 1. *Exports, wherever the property may be and without restriction as to time, if the coverage includes hazards of transportation.*
2. *An export, as a proper subject of marine and transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of paragraph (c) of this subsection shall apply.*
3. *This paragraph shall not apply to long-established methods of insuring certain commodities;*~~["Marine protection and indemnity insurance" meaning insurance against, or against legal liability of the insured for, loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of any vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person. ]~~
- (c) 1. *Domestic shipments on consignment, for sale or distribution, exhibit, trial, approval, or auction, while in transit, while in the custody of others, and while being returned, except in no event shall the insurance cover on premises owned, leased, or operated by the consignor; and*
2. *Domestic shipments not on consignment, if the coverage includes hazards of transportation, beginning and ending within the United States, but the shipments shall not be covered:*
- a. *At the manufacturing premises; or*
- b. *After arrival at premises owned, leased, or operated by an insured or purchaser;*
- (d) *Bridges, tunnels, and other instrumentalities of transportation and communication, which:*
1. *Include:*
- a. *Bridges, tunnels, and other similar instrumentalities, including auxiliary facilities and equipment attendant thereto;*
- b. *Piers, wharves, docks, slips, dry docks, and marine railways;*
- c. *Pipelines, including on-line propulsion, regulating, and other equipment appurtenant to the pipelines, but excluding all property at the manufacturing, producing, refining, converting, treating, or conditioning plant;*
- d. *Power transmission, telephone, and telegraph lines, but excluding all property at generating, converting, or transforming stations, substations, or exchanges;*
- e. *Radio and television communication equipment in use, as such, including towers, antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus; and*
- f. *Outdoor cranes, loading bridges, and similar equipment used to load, unload, or transport; and*
2. *Exclude buildings, improvements and betterments to buildings, furniture and furnishings, fixed contents, and supplies held in storage;*
- (e) *Personal property floater risks covering an individual, or generally, including:*
1. *Personal effects floaters;*
2. *Personal property floaters;*
3. *Government service floaters;*
4. *Personal fur floaters;*
5. *Personal jewelry floaters;*
6. *Wedding present floaters that do not exceed ninety (90) days after the date of the ceremony;*
7. *Silverware floaters;*

8. *Fine art floaters that cover paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art that are of rarity, historical value, or artistic merit;*
  9. *Stamp and coin floaters;*
  10. *a. Musical instrument floaters.*  
*b. As used in this subparagraph, "musical instrument" does not include radios, televisions, record players, or a combination thereof;*
  11. *Mobile article, machinery, and equipment floaters that:*  
*a. Cover identified property of a mobile or floating nature pertaining to or usual to a household; and*  
*b. Exclude:*  
*i. Motor vehicles designed for highway use;*  
*ii. Auto homes, trailers, and semi-trailers, except when hauled by a tractor not designed for highway use; and*  
*iii. Furniture and fixtures not customarily used away from premises where the property is usually kept;*
  12. *a. Installment sales and leased property insurance that:*  
*i. Covers property pertaining to a household and sold under a conditional contract of sale, partial payment contract, installment sales contract, or lease; and*  
*ii. Excludes motor vehicles designed for highway use.*  
*b. Installment sales and leased property insurance shall cover in transit, but shall not extend beyond the termination of the seller's or lessor's interest; and*
  13. *Live animal floaters; and*
- (f) *Commercial property floater risks that cover property pertaining to a business, profession, or occupation, including:*
1. *Radium floaters;*
  2. *Physician's and surgeons' instrument floaters, which may include coverage of furniture, fixtures, and a tenant insured's interest in improvements and betterments of buildings located in that portion of the premises occupied by the insured in the practice of his or her profession;*
  3. *Pattern and die floaters;*
  4. *Theatrical floaters that exclude:*  
*a. Buildings;*  
*b. Improvements and betterments to buildings; and*  
*c. Furniture and fixtures that do not travel about with theatrical troupes;*
  5. *Film floaters, including:*  
*a. Builders' risk during the production; and*  
*b. Coverage on the completed negatives and positives and sound records;*
  6. *Salesmen's samples floaters;*
  7. *Exhibition insurance on property while on exhibition and in transit to or from an exhibition;*
  8. *Live animal floaters;*
  9. *Builders risks or installation risks insurance that:*  
*a. Covers the interest of an owner, seller, or contractor against loss or damage to machinery, equipment, or building materials or supplies being used with and during the course of installation, testing, building, renovating, or repairing;*

- b. *May cover:*
    - i. *At points or places where work is being performed;*
    - ii. *While in transit; and*
    - iii. *During temporary storage or deposit of property designated for and awaiting specific installation, building, renovating, or repairing;*
  - c. *Is limited to builders risks or installation risks where perils in addition to fire and extended coverage are to be insured; and*
  - d.
    - i. *If written for an owner, ceases upon completion and acceptance thereof; or*
    - ii. *If written for a seller or contractor, terminates when the interest of the seller or contractor ceases;*
10. *Mobile article, machinery, and equipment floaters that:*
- a. *Cover identified property of a mobile or floating nature, not on sale or consignment, or in the course of manufacture, which has come into the custody or control of parties who intend to use the property for which it was manufactured or created; and*
  - b. *Exclude:*
    - i. *Motor vehicles designed for highway use;*
    - ii. *Auto homes, trailers, and semi-trailers except when hauled by a tractor not designed for highway use;*
    - iii. *Snow plows constructed exclusively for highway use; and*
    - iv. *Furniture and fixtures not customarily used away from premises where the property is usually kept;*
11. *Insurance that:*
- a. *Covers property:*
    - i. *In transit to, or from and in, the custody of a bailee; and*
    - ii. *That is not owned, controlled, or operated by the bailor; and*
  - b. *Excludes the property of the bailee at his or her premises;*
12. a. *Installment sales and leased property insurance that:*
- i. *Covers property sold under a conditional contract of sale, partial payment contract, installment sales contract, or lease; and*
  - ii. *Excludes motor vehicles designed for highway use and machinery and equipment under a certain "lease-back" contract.*
- b. *Installment sales and leased property insurance shall cover in transit, but shall not extend beyond the termination of the seller's or lessor's interest;*
13. *Garment contractor floaters;*
14. *Furriers or fur storer customer insurance:*
- a. *Under which certificates or receipts are issued by furriers or fur storers; and*
  - b. *That covers specified articles of a customer's property;*
15. *Accounts receivable insurance;*
16. *Valuable papers and records insurance;*
17. *Floor plan insurance that:*

- a. *Covers property for sale while in possession of a dealer under a floor plan or any similar plan under which the dealer may borrow money from a bank or lending institution with which to pay the manufacturer, if:*
    - i. *The merchandise is specifically identifiable as encumbered to the bank or lending institution;*
    - ii. *The dealer's right to sell or otherwise dispose of the merchandise is conditioned upon the merchandise being released from encumbrance by the bank or lending institution; and*
    - iii. *The insurance covers in transit and does not extend beyond the termination of the dealer's interest; and*
  - b. *Excludes:*
    - i. *Automobiles or motor vehicles; and*
    - ii. *Merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution;*
18. *Sign and street clock insurance, which includes coverage for neon signs, automatic or mechanical signs, and street clocks, while in use as such;*
19. *Fine arts insurance that covers paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value, or artistic merit for a museum, gallery, university, business, municipality, or other similar interest;*
20. a. *Insurance that covers personal property which, when sold to the ultimate purchaser, may be covered specifically by the owner under an inland marine policy, certificate, or contract, including:*
  - i. *Musical instrument dealers insurance that covers property consisting principally of musical instruments and their accessories. As used in this subpart, "musical instrument" does not include radios, televisions, record players, or a combination thereof;*
  - ii. *Camera dealers insurance that covers property consisting principally of cameras and their accessories;*
  - iii. *Furrier dealers insurance that covers property consisting principally of furs and fur garments;*
  - iv. *Equipment dealers insurance that covers mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders, and other similar agricultural equipment and accessories and construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and other similar equipment and accessories. Equipment dealers insurance shall exclude motor vehicles designed for highway use;*
  - v. *Stamp and coin dealers insurance that covers property of philatelic and numismatic nature;*
  - vi. *Jewelers block insurance; and*
  - vii. *Fine art dealers insurance.*
- b. *For any insurance referenced in subdivision a. of this subparagraph, the insurance may include coverage of:*
  - i. *Money in locked safes or vaults on the insured's premises; and*
  - ii. *Furniture, fixtures, tools, machinery, patterns, molds, dies, and tenant insureds' interests in building improvements;*
21. *Wool growers floaters;*
22. *Domestic bulk liquid insurance that covers tanks and domestic bulk liquids stored therein;*

23. *Difference in condition coverage that excludes fire and extended coverage perils; and*

24. *Electronic data processing insurance.*

(2) *Subsection (1) of this section shall not be construed to permit coverage under an inland marine policy, certificate, or contract for the following, unless the coverage is otherwise permitted under that subsection or this chapter:*

(a) *Storage of the insured's merchandise;*

(b) *Merchandise in the course of manufacture, including the property of, and on the premises of, the manufacturer;*

(c) *Furniture and fixtures;*

(d) *Improvements and betterments to buildings; or*

(e) *Moneys or securities held in safes, vaults, safety deposit vaults, or banks, or on the premises of an insured, except while in the course of transportation.*

(3)~~(2)~~ (a) *As used in this chapter*~~[For the purposes of this code], "wet marine and transportation insurance" means~~~~[is that part of]~~ marine and transportation insurance *that may cover or include*~~[which includes only]:~~

1.~~(a)~~ ~~[Insurance upon]~~ Vessels, crafts, hulls, and of interests therein or with relation thereto;

2.~~(b)~~ ~~[Insurance of]~~ Marine builders' risks, marine war risks, and contracts of marine protection and indemnity insurance;

3.~~(c)~~ ~~[Insurance of]~~ Freights and disbursements pertaining to a subject of insurance coming within this definition; and

4.~~(d)~~ ~~[Insurance of]~~ Personal property and interests therein, in course of exportation from or importation into any country, or in course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit, or transportation, and while being prepared for and while awaiting shipment, and during any delays, storage, transshipment, or reshipment incident thereto.

(b) *As used in this subsection, "marine protection and indemnity insurance":*

1. *Means insurance against, or against legal liability of the insured for, loss, damage, or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways; and*

2. *Includes liability of the insured for personal injury, illness, or death or loss of or damage to the property of another person.*

➔Section 8. KRS 304.9-035 is amended to read as follows:

(1) Any insurer shall be liable for the acts of its agents *and adjusters* when the agents *or adjusters* are acting:

(a) In their capacity as representatives of the insurer; and~~[are acting]~~

(b) Within the scope of their authority.

(2) Licensed individuals designated by a business entity to exercise the business entity's:

(a) Agent license shall be deemed agents of ~~an~~~~the~~ insurer if the business entity holds an appointment from the insurer; *and*

(b) *Adjuster license on behalf of an insurer shall be deemed an adjuster of the insurer.*

➔Section 9. KRS 304.9-051 is amended to read as follows:

As used in KRS 304.9-052 and 304.9-371 to 304.9-377:

(1) (a) An "administrator" is an individual or business entity ~~that~~~~who~~ collects charges or premiums from, or ~~that~~~~who~~ adjusts or settles claims on, residents of this state in connection with life insurance, health

insurance, annuities, nonprofit hospital, medical-surgical, dental, and health service corporation contracts, health maintenance organization contracts, or other life, health, or annuity benefit plans.

(b) The following are not considered to be acting as *an* administrator:

1. ~~(a)~~ An employer acting on behalf of its employees or the employees of one (1) or more subsidiary or affiliated corporations of the employer;
2. ~~(b)~~ A union on behalf of its members;
3. ~~(c)~~ An insurer, which is acting as the insurer with respect to the contract if the insurer is authorized or permitted to transact business in Kentucky or if the contract is lawfully delivered or issued for delivery by it in and pursuant to the laws of a state in which it was authorized or permitted to do business;
4. ~~(d)~~ A life or health insurance agent licensed in Kentucky whose activities are limited exclusively to the sale of insurance;
5. ~~(e)~~ A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;
6. ~~(f)~~ A trust, its trustees, agents, and employees acting thereunder, established in conformity with 29 U.S.C. sec. 186;
7. ~~(g)~~ A trust exempt from taxation under 26 U.S.C. sec. 501(a), its trustees, and employees acting thereunder, or a custodian, its agents, and employees acting pursuant to a custodian account which meets the requirements of 26 U.S.C. sec. 401(f);
8. ~~(h)~~ A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;
9. ~~(i)~~ A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, *if the* ~~provided such~~ company does not adjust or settle claims; ~~or~~
10. ~~(j)~~ An individual who:
  - a. Adjusts or settles claims in the normal course of practice or employment as an attorney-at-law; ~~and~~ ~~who~~
  - b. Does not collect charges or premiums in connection with coverages issued by insurers; *or*
11. *An individual working for a business entity that is licensed as an administrator to the extent that the individual's job responsibilities are subject to the supervision and control of the business entity.*

(2) An "insured" is a person covered under an insurance contract, nonprofit hospital, medical-surgical, dental, and health service corporation contract, health maintenance organization contract, or other source of benefits.

➔Section 10. KRS 304.9-085 is amended to read as follows:

- (1) A "managing general agent" is an individual or business entity appointed by an insurer to solicit applications from agents for insurance contracts or to negotiate insurance contracts on behalf of an insurer and, if authorized to do so by an insurer, to effectuate and countersign insurance contracts.
- (2) (a) ~~An~~ ~~No~~ individual or business entity ~~shall~~ in this state *shall not* be, act as, or hold himself, herself, or itself out as a managing general agent unless then licensed as a managing general agent. In order to qualify for a managing general agent license, an individual shall:
  1. ~~(a)~~ Hold an agent license with property and casualty lines of authority and be appointed by each authorized insurer the licensee holds the contract to represent;
  2. ~~(b)~~ If a nonresident, hold a nonresident agent license with property and casualty lines of authority and be appointed by each authorized insurer the licensee holds a contract to represent in Kentucky; and
  3. ~~(c)~~ Hold a surplus lines broker license if any unauthorized insurers are represented or used.
- (b) In order for a business entity to qualify for a managing general agent license, all individuals acting on behalf of the business entity under its license shall be:

1. Licensed agents with property and casualty lines of authority; and ~~shall be~~
  2. Designated with the commissioner as to the license in accordance with all provisions of KRS 304.9-133 ~~except for subsection (2)(a).~~
- (3) As used in this chapter, "agent" includes managing general agent unless the context requires otherwise.
- (4) (a) A managing general agent is a representative of the insurers which the managing general agent holds a contract to represent.
- (b) Each insurer is liable for the acts of the managing general agent in representing that insurer.
- (5) The commissioner shall renew managing general agent licenses in accordance with KRS 304.9-260.

➔Section 11. KRS 304.9-105 is amended to read as follows:

- (1) An individual applying for an agent license shall make application to the commissioner on the uniform individual application or other application prescribed by the commissioner. Before approving the application, the commissioner shall find that the applicant:
- (a) Is at least eighteen (18) years of age;
  - (b) Has fulfilled the residence requirements as set forth in KRS 304.9-120 or is a nonresident who is not eligible to be issued a license in accordance with KRS 304.9-140;
  - (c) Has not committed any act that is a ground for denial, suspension, or revocation set forth in KRS 304.9-440;
  - (d) Is trustworthy, reliable, and of good reputation, evidence of which shall be determined through an investigation by the commissioner;
  - (e) 1. Is competent to exercise the license and has:
    - a.~~1.~~ Except for variable life and variable annuities line of authority and limited lines of authority identified in KRS 304.9-230;~~;~~
      - i. Completed a prelicensing course of study consisting of forty (40) hours for life and health, forty (40) hours for property and casualty, or twenty (20) hours for each line of authority, as applicable, for which the individual has applied~~. The commissioner shall promulgate administrative regulations to carry out the purpose of this section;~~ and
      - ii.~~2.~~ ~~Except for variable life and variable annuities line of authority and limited lines of authority identified in accordance with KRS 304.9-230,~~ Successfully passed the examinations required by the commissioner for the lines of authority for which the individual has applied; and
    - b.~~3.~~ Paid the fees set forth in KRS 304.4-010.~~;~~ and
  2. ***The commissioner shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this paragraph; and***
- (f) Is financially responsible to exercise the license and has maintained in effect while so licensed:
  1. The certificate of an insurer, ***which states*** that the insurer has and will keep in effect on behalf of the person a policy of insurance covering the legal liability of the licensed person as the result of erroneous acts or failure to act in his or her capacity as an insurance agent, and enuring to the benefit of any aggrieved party as the result of any single occurrence in the sum of not less than twenty thousand dollars (\$20,000) and one hundred thousand dollars (\$100,000) in the aggregate for all occurrences within one (1) year;
  2. A cash surety bond executed by an insurer, in the sum of twenty thousand dollars (\$20,000), which shall be subject to lawful levy of execution by any party to whom the licensee has been found to be legally liable as the result of erroneous acts or failure to act in his or her capacity as an agent; or
  3. An agreement by an insurer or group of affiliated insurers for which he or she is or is to become an exclusive agent whereby the insurer or group of affiliated insurers agrees to assume

responsibility, to the benefit of any aggrieved party, for legal liability of the licensed person as the result of erroneous acts or failure to act in his or her capacity as an insurance agent on behalf of the insurer or group of affiliated insurers in the sum of twenty thousand dollars (\$20,000) for any single occurrence and that the agreement shall not be terminated until the **insurer appointment is terminated**~~[license is surrendered to the commissioner].~~

(2) The commissioner may:

- (a) Require additional information or submissions from applicants; and~~[may]~~
- (b) Obtain any documents or information reasonably necessary to verify the information contained in an application.

➔Section 12. KRS 304.9-133 is amended to read as follows:

(1) *As used in this section, "licensed business entity" means* a business entity issued a:

- (a) License *under*~~[in accordance with]~~ this subtitle;~~;~~ or~~[issued a]~~
- (b) Life settlement broker,~~[or]~~ life settlement provider, *or surplus lines broker* license.~~;~~

(2) (a) *Except as provided in this subsection:*

- 1. *A licensed business entity* shall designate~~[only]~~ individuals to act under the business entity license; *and*
- 2. *Each individual designated to act under the license of a business entity referenced in subparagraph 1. of this paragraph shall hold the same kind of license as the business entity.*

- (b) *A portable electronics retailer issued a license shall designate a business entity to act under the license.*
- (c) *A managing general agent issued a license shall designate individuals licensed as agents with property and casualty lines of authority to act under the license.*
- (d) *A pharmacy benefit manager issued a license shall designate individuals licensed as administrators to act under the license.*

~~(3)(2)~~ (a) *The first individual designated by a licensed business entity to act under the business entity license*~~[Each designated individual]~~ shall~~;~~

- ~~(a) Hold the same kind of license as the business entity;~~
- ~~(b) If the business entity license has lines of authority,~~ have one (1) or more of the same lines of authority *as the business entity.*~~;~~~~and~~
- ~~(b)(c)~~ *An individual designated to act under the business entity license who is in addition to the first designee referenced in paragraph (a) of this subsection shall*~~[If the individual is designated under an agent license,]~~ have at least one (1) appointment with an insurer.

~~(4)(3)~~ A~~[The]~~ licensed business entity shall file with the commissioner:

- (a) Notice of the designation of an individual within thirty (30) days of the designation; and
- (b) Notice of termination of designation of an individual within thirty (30) days of the termination of designation.

~~(5)(4)~~ (a) *Except as provided in subsection (2)(b) of this section,* a licensed business entity shall exercise its license only through *one (1) or more*~~[a]~~ designated individual *licensees*~~[licensee].~~

~~(b)(a)~~ 1. The business entity shall have for each of its *licenses and* active lines of authority at least one (1) licensed individual~~[with the same line of authority]~~ designated with the commissioner *at all times.*

2. If the business entity fails to have at least one (1) licensed individual designated with the commissioner for a line of authority, that line of authority shall become inactive~~;~~~~and~~

~~(b)~~ ~~The business entity shall have at least one (1) licensed individual designated with the commissioner at all times].~~

3. If the business entity fails to have at least one (1) *licensed* individual designated with the commissioner, the business entity license shall terminate ~~and shall be promptly surrendered to the commissioner without demand~~.

~~(6)(5)~~ An insurer that has appointed the business entity licensee shall be responsible for the acts of each designated individual performed under the business entity's license as if the insurer had appointed the individual licensee.

➔Section 13. KRS 304.9-135 is amended to read as follows:

(1) As used in this section:

(a) "Financial institution" means:

1. A bank or bank holding company, as defined in the Bank Holding Company Act of 1956, ~~as amended,~~ **codified at** 12 U.S.C. sec. 1841, **as amended**;
2. A savings bank, savings and loan association, trust company, or any depository institution as defined ~~in~~**by** the Federal Deposit Insurance Act, **codified at** ~~in~~ 12 U.S.C. sec. 1813(c)(1), **as amended**; and
3. Any other individual, corporation, partnership, or association authorized to take deposits and make loans in ~~this~~**the** Commonwealth, and any affiliate or subsidiary of any of the above;

(b) "Insurance agency activities" means any activity relating to insurance, other than title insurance, for which a license as agent, reinsurance intermediary broker or manager, ~~specialty credit producer or managing employee,~~ surplus lines broker, or consultant is required under this chapter; and

(c) "Insurance information" means any information concerning premiums, terms, and conditions of insurance coverage, including:

1. Expiration dates and rates;~~;~~ and
2. Claims maintained in the records of the financial institution or affiliate.

(2) A financial institution authorized by law to engage in insurance agency activities in this state shall, in addition to any other applicable requirements, comply with the following requirements:

- (a) The financial institution or officer, agent, representative, or employee thereof shall qualify for licensure under all applicable provisions of this chapter and abide by all applicable provisions of this chapter and applicable administrative regulations;
- (b) A financial institution shall provide a written statement to a consumer regarding the consumer's free choice of agent and insurer according to KRS 304.12-150, when the consumer's application for a loan or other extension of credit from the financial institution is pending and when insurance is offered to the consumer, sold to the consumer, or required in connection with the loan or extension of credit by the financial institution or affiliate;
- (c) A financial institution shall not release a consumer's insurance information to any person or entity for the solicitation or selling of insurance, other than an officer, director, employee, agent, or affiliate of a financial institution, without prior disclosure to the consumer and the opportunity for the consumer to prevent the disclosure;
- (d) A financial institution shall not release or use health information obtained from the insurance records of a consumer for any purpose, other than activities of a licensed agent, administrator, reinsurance intermediary broker or manager, ~~specialty credit producer or managing employee,~~ surplus lines broker, or consultant, without the written consent of the consumer;
- (e) A financial institution licensed by the department to engage in insurance agency activities shall:
  1. Not violate the anti-tying provisions of the Bank Holding Company Act **Amendments of 1970, codified at** 12 U.S.C. ~~sec.~~**sec.** 1971 et seq., in effect as of December 31, 1997; and
  2. Notify the department in writing within ten (10) days of any final judgment or any final administrative action, by a federal agency authorized to enforce the anti-tying provision, that finds that the financial institution or any of its employees committed a violation of the Bank

Holding Company Act. Any such final and unappealable judgment or final and unappealable administrative action shall be deemed a violation of this chapter;

- (f) Prior to the sale of any policy of insurance to a consumer, a financial institution shall, when practicable, provide to the consumer a written statement that:
  - 1. The insurance offered by the financial institution is not a deposit;
  - 2. The insurance offered by the financial institution is not insured by the Federal Deposit Insurance Corporation or other government agency that insures deposits;
  - 3. The insurance offered by the financial institution is not guaranteed by the financial institution or any affiliate;
  - 4. The insurance may involve investment risk, including potential loss of principal; and
- (g) The commissioner shall promulgate administrative regulations in accordance with KRS Chapter 13A that specify the disclosure forms required by subsections (b), (c), and (f) of this section.
- (3) An officer or employee of a financial institution shall not directly or indirectly delay or impede the completion of a loan transaction or any other transaction with a financial institution for the purpose of influencing a consumer's selection or purchase of any insurance.
- (4) A financial institution shall not use any advertisement or promotional material causing a reasonable person to mistakenly believe that:
  - (a) The federal government or any state guarantees the insurance sales activities of financial institutions or guarantees the credit of the financial institution; or
  - (b) Any state or federal government guarantees any return on insurance products or is a source of payment on any insurance product sold by the financial institution.
- (5) A financial institution shall use separate documentation for all credit and insurance transactions when a consumer obtains insurance and credit, other than credit insurance, from a financial institution or any individual or business entity soliciting or selling insurance on the premises of a financial institution.
- (6) A financial institution shall not include an expense of insurance premiums in a credit transaction when a consumer obtains insurance and credit, other than credit insurance, from a financial institution or any individual or business entity soliciting or selling insurance on the premises of a financial institution, without the written consent of the consumer.
- (7) (a) A financial institution shall maintain separate and distinct books and records relating to insurance transactions conducted through the financial institution, including files relating to consumer complaints.
- (b) The books, records, and files shall be made available to the commissioner for inspection in accordance with KRS 304.2-220.

➔Section 14. KRS 304.9-140 is amended to read as follows:

- (1) ~~Unless denied a license in accordance with KRS 304.9-440, ]~~A nonresident individual or business entity shall receive the applicable insurance producer license if:
  - (a) The applicant is currently licensed as a resident and in good standing in his or her home state;
  - (b) The applicant has submitted the proper request for license and has paid the fees required by KRS 304.4-010 and administrative regulations;
  - (c) The applicant has submitted or transmitted to the commissioner the application for a license that the applicant submitted to his or her home state or a completed uniform individual application or uniform business entity application;~~and~~
  - (d) The applicant's home state awards nonresident licenses to residents of this state on the same basis; *and*
  - (e) ***The applicant is not denied a license in accordance with KRS 304.9-440.***
- (2) The commissioner may verify the applicant's license status through the database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

- (3) A nonresident licensee who changes his or her home state to a state other than Kentucky shall file a change of address and provide certification from the new home state within thirty (30) days of the change of home state. No fee or license application is required.
- (4) Notwithstanding any other provisions of this chapter, ~~on or after July 1, 2002,~~ an individual licensed as a surplus lines broker in his or her home state shall receive a nonresident surplus lines broker license by meeting the requirements of subsection (1) of this section. Except as **provided in** ~~to~~ subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of Subtitle 10 of this chapter.
- (5) Notwithstanding any other provision of this subtitle, an individual licensed as a limited lines agent in his or her home state shall receive a nonresident limited lines agent license in accordance with subsection (1) of this section, granting the same scope of authority as granted under the license issued by the agent's home state.
- (6) ***Notwithstanding any other provision of this subtitle, an individual licensed as an agent with a limited line of authority in his or her home state shall:***
- (a) ***Receive a nonresident major line of authority in accordance with subsection (1) of this section if the limited line of authority in the individual's home state is not offered in this state; and***
  - (b) ***Only have authority to place business under the nonresident license with a major line of authority in this state to the extent permitted, and as limited, for an individual agent in the individual's home state with the limited line of authority.***
- (7) The commissioner shall waive any requirements for a nonresident ***insurance producer*** license applicant with a valid license from his or her home state, except the requirements imposed by subsection (1) of this section, if the applicant's home state awards nonresident ***insurance producer*** licenses to residents of Kentucky on the same basis.
- ~~(8)~~~~(7)~~ (a) As a condition to or in connection with the continuation of an insurance producer license issued under this section, the licensee must maintain the applicable license in his or her home state.
- (b) The insurance producer license issued under this section shall terminate ~~and be surrendered to the commissioner~~ if and when the licensee's applicable home state license terminates for any reason.

➔Section 15. KRS 304.9-170 is amended to read as follows:

~~No~~Prelicensing education or examination shall **not** be required of:

- (1) (a) An individual licensee who allows his or her license to lapse if the license renewal fee is paid within twelve (12) months from the due date of the license renewal fee, **except** ~~However,~~ a penalty in the amount of double the unpaid renewal fee shall be imposed.
- (b) The department shall issue a license with the same lines of authority as the lapsed license; ~~;~~
- ~~(2)~~~~(b)~~ Any applicant for **a** license covering any line of authority to which the applicant was licensed under a similar license in Kentucky, other than a temporary license, within the twelve (12) months next preceding **the** date of application, **except** ~~;~~ the applicant is not eligible for this exemption if the previous license was revoked or suspended by the commissioner for reasons other than failure to ~~maintain financial responsibility or to~~ meet continuing education requirements as required by KRS ~~304.9-105 and~~ 304.9-295; ~~;~~
- ~~(3)~~~~(e)~~ A licensed insurance agent operating as a life settlement broker pursuant to KRS 304.15-700(2)(b); ~~;~~
- ~~(4)~~~~(2)~~ (a) An individual who applies for an insurance producer license in Kentucky who was previously licensed for the same lines of authority in another state ~~shall not be required to complete any prelicensing education or examination~~.
- (b) This exemption is only available if:
  1. The applicant is currently licensed in the other state; or ~~if~~
  2.
    - a. The application is received within ninety (90) days of the cancellation of the applicant's previous license; and ~~if~~
    - b. The prior state issues a certification that, at the time of cancellation: ~~;~~
      - i. The applicant was in good standing in that state; or
      - ii. The state's database records, maintained by the National Association of Insurance

Commissioners, its affiliates, or subsidiaries, indicate that the insurance producer is or was licensed in good standing for the line of authority requested; ~~[-]~~

(5)~~(3)~~ **Except as otherwise established by the commissioner in an administrative regulation**, an individual **who:**

- (a) Was licensed as **a resident**~~an~~ insurance producer in another state within the last twelve (12) months;~~[-]~~  
~~who~~
- (b) Moves to Kentucky; ~~and~~~~[-]~~~~shall make~~
- (c) **Makes an** application within ninety (90) days of establishing legal residence **in Kentucky** to become a resident licensee in accordance with KRS 304.9-105~~[-]~~. ~~No prelicensing education or examination shall be required of that applicant to obtain a license~~ for any line of authority previously held in the prior home state **within the last twelve (12) months**; ~~except where the commissioner determines otherwise by administrative regulation.~~

(6)~~(4)~~ An applicant for an insurance producer's license who is currently licensed in Kentucky as a consultant as to the same line of authority, or has been so licensed within twelve (12) months next preceding the date of application for the license, unless the previous license was revoked or suspended or continuation thereof refused by the commissioner for reasons other than failure to maintain financial responsibility as required by KRS 304.9-330; ~~or~~~~[-]~~

(7)~~(5)~~ Any applicant for **a** license covering the same line of authority as to which that applicant~~[-]~~~~shall have~~ held a valid license issued in accordance with this subtitle or other applicable Kentucky law which was surrendered, in accordance with KRS 304.2-080 or other applicable law, in order to accept employment with the Department of Insurance, **except**~~provided, however, that~~ the applicant shall apply for relicensing within twelve (12) months of the date of termination of his or her employment with the Department of Insurance.

➔Section 16. KRS 304.9-200 is amended to read as follows:

**For licenses**~~(4)~~~~—The license~~ issued under this subtitle or to a surplus lines broker, life settlement broker, or life settlement provider:

- (1) **The license** shall contain the licensee's name, city and state of principal place of business address, personal identification number, and the date of issuance, the lines of authority, and any other information the commissioner deems necessary; ~~[-]~~
- (2) The licensee shall inform the commissioner in writing in a format acceptable to the commissioner of a change of address or change of legal name within thirty (30) days of the change; ~~[-]~~
- (3) (a) After completion of application for a license, completion of any prelicensing education required under this chapter, payment of applicable fees, and the taking and passing of any examination required under this chapter, the commissioner shall promptly consider the application.  
(b) If the commissioner finds that the applicant has fully met the requirements for licensure, the commissioner shall promptly issue the license to the applicant; otherwise, the commissioner shall refuse to issue the license and promptly notify the applicant of the refusal, stating the grounds thereof; ~~[-]~~
- (4) ~~If a license is refused, the commissioner shall promptly refund any appointment fee tendered with the license application.~~ All **application and examination**~~other~~ fees~~[-]~~~~for application for license or examination~~ shall be deemed earned when paid and shall not be refundable **if a license is refused**; ~~and~~~~[-]~~
- (5) In order to assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or its affiliate or subsidiary, to perform ministerial functions, including the collection of fees or data related to licensing.

➔Section 17. KRS 304.9-230 is amended to read as follows:

- (1) The commissioner may issue, in accordance with KRS 304.9-080, an agent's license with the limited line of authority as follows:
  - (a) **Preneed funeral**~~Surety~~;
  - (b) Travel;
  - (c) Limited line credit;
  - (d) Crop;

- (e) Rental vehicle;
  - (f) Self-service storage space; or
  - (g) Other limited lines, as specified by the commissioner through the promulgation of administrative regulations.
- (2) The commissioner shall promulgate administrative regulations to establish the requirements, if any, for prelicensing courses of instruction and examination for each limited line of authority.
- (3) ~~On and after July 15, 2002,~~ The commissioner shall not issue an agent license with a limited line of authority for motor vehicle physical damage or for mechanical breakdown insurance. However, an agent license with a limited line of authority for motor vehicle physical damage or for mechanical breakdown insurance in effect on July 15, 2002, shall continue in effect until surrendered or otherwise terminated in accordance with this subtitle.

➔Section 18. KRS 304.9-260 is amended to read as follows:

- (1) (a) *As used in this subsection, "license" means a:*
- 1. ~~Each~~ License issued under this subtitle;~~;~~
  - 2. Surplus lines broker license;~~;~~
  - 3. Life settlement broker license; ~~or~~, ~~and~~
  - 4. Life settlement provider license.
- (b) *Each license* shall continue in force until expired, suspended, revoked, or otherwise terminated.
- (c) License renewal fees shall be received on or before the applicable due date for the license as stated in KRS 304.4-010.
- (d) ~~Beginning January 1, 2003,~~ A request for *license* renewal shall be on a form or in a format prescribed by the commissioner. ~~and made as follows:~~
- (e) ~~(a)~~ At least thirty (30) days before the *license* renewal request and fees are due from *each respective* ~~the~~ licensee, the department shall make available to *the* ~~each respective~~ licensee a list of his or her licenses to be renewed during that calendar year. ~~With the licensee's written consent, an insurer or the licensee's employer may request that the department send the renewal list to the insurer or to the employer. The department may distribute the renewal list to the requesting insurer or employer instead of to the licensee;~~
- (f) ~~(b)~~ In conjunction with license renewal, *the following individuals shall show proof of compliance with continuing education requirements established in Section 20 of this Act:* ~~an individual holding a~~
- 1. Resident: ~~license for agent, independent or public adjuster, and life settlement broker shall show proof of compliance with continuing education pursuant to KRS 304.9-295]~~
    - a. *Agents;*
    - b. *Independent adjusters;*
    - c. *Public adjusters; and*
    - d. *Life settlement brokers; and*
  - 2. *Nonresident:*
    - a. *Independent adjusters; and*
    - b. *Public adjusters;*

*that designate Kentucky as their home state.*
- (g) 1. An individual licensee whose birth date is in an even-numbered year shall submit the *license* renewal request, continuing education course completion documentation pursuant to KRS 304.9-295, and fees to the commissioner by the last day of the licensee's birth month in the next even-

numbered year after the date the license is issued, and each subsequent even-numbered year thereafter;

2. ~~[(c)]~~ ~~[In conjunction with license renewal, an individual holding a resident license for agent, independent or public adjuster, and life settlement broker shall show proof of compliance with continuing education pursuant to KRS 304.9-295.]~~ An individual licensee whose birth date is in an odd-numbered year shall submit the *license* renewal request, continuing education course completion documentation pursuant to KRS 304.9-295, and fees to the commissioner by the last day of the licensee's birth month in the next odd-numbered year after the date the license is issued, and each subsequent odd-numbered year thereafter;
  3. ~~[(d)]~~ A business entity that is issued a license in an even-numbered year shall submit the *license* renewal request and fees to the commissioner by March 31 of the next even-numbered year, and each subsequent even-numbered year thereafter; and
  4. ~~[(e)]~~ A business entity that is issued a license in an odd-numbered year shall submit the *license* renewal request and fees to the commissioner by March 31 of the next odd-numbered year, and each subsequent odd-numbered year thereafter.
- (2) (a) Any license referred to in subsection (1) of this section for which the request for renewal, any required continuing education course completion documentation, if applicable, and fee are not received by the commissioner shall be deemed to have expired at midnight on the last day of the birth month for individuals and on March 31 for business entities. ~~;~~
  - (b) Any renewal request and fees received by the commissioner within sixty (60) days after the date of expiration ~~;~~ may be accepted with no interruption in license if accompanied by a penalty as provided in *Section 33 of this Act.* ~~[Subtitle 99 of this chapter; and]~~
  - (c)
    1. Completion of the required continuing education course, if applicable, shall be on or before the expiration date, which is deemed as the last day of the birth month of the licensee during the applicable odd or even year on a biennial basis.
    2. Proof of compliance shall be received by the commissioner within sixty (60) days after the expiration date.
- (3) A licensee who is unable to comply with *the* license renewal procedures *of this section* due to military service, long-term medical disability, or some other extenuating circumstance may make a written request for a waiver of those procedures. The licensee may also make a written request for a waiver of any examination requirement, fine, or other sanction imposed for failure to comply with these renewal procedures.
  - (4) As a condition to or in connection with the continuation of any insurance producer license, the commissioner may require the licensee to file with him or her information relative to use made of the license during the next preceding calendar year and especially as to whether the license has been used principally for the writing of controlled business, as defined in KRS 304.9-100.
  - (5) As a condition to or in connection with the continuation of any license *referred to in subsection (1) of this section*, the commissioner shall require continuous demonstration of continuing education course completion to sustain the license, and any license shall terminate ~~[and be surrendered to the commissioner]~~ if and when the demonstration becomes impaired.
  - (6) This section does not apply to temporary licenses issued under KRS 304.9-300, and licensees not licensed for one (1) full year prior to the end of the applicable biennial renewal year.
- ➔Section 19. KRS 304.9-270 is amended to read as follows:
- (1) (a) Each insurer appointing an agent ~~[, including managing general agent, rental vehicle agent, rental vehicle managing employee, specialty credit producer, and specialty credit managing employee.]~~ in this state shall obtain approval of the appointment from the commissioner by:
    1. Filing with the commissioner the notice of appointment, specifying the lines of authority to be transacted by the agent for the insurer; ~~;~~ and
    2. *Submitting* ~~[submit]~~ the appointment fee, as specified in KRS 304.4-010.
  - (b) Each insurer shall notify the commissioner of additional lines of authority for which *an agent* ~~[a licensee]~~ is deemed authorized to transact business, after the initial appointment, in a format prescribed by the commissioner.

- (2) Prior to appointment *of an agent*, the insurer shall satisfy itself through investigation that the named applicant has not been convicted of any felony offense involving dishonesty or a breach of trust and has not been convicted of a fraudulent insurance act under Subtitle 47 of this chapter, unless the named applicant has received written consent from the commissioner that specifically refers to KRS 304.47-025(3).
- (3) No agent shall claim to be an agent or representative of, or in any way imply a contractual relationship with, a particular insurer, or place applications for insurance with an insurer unless:
  - (a) The agent becomes an appointed agent of the insurer; and
  - (b) The agent's appointment has been approved by the commissioner.
- (4) (a) An agent may act as a representative of and place insurance with an insurer without first obtaining approval of the appointment by the commissioner for a period of fifteen (15) days from the date the first insurance application is executed by the agent.
  - (b) If the agent does not obtain confirmation that the agent's appointment has been approved by the commissioner within fifteen (15) days from the date the first insurance application is executed, the agent shall immediately discontinue acting as an agent on behalf of the insurer until confirmation is received.
- (5) (a) The insurer shall, no later than fifteen (15) days from the date the agent contract is executed or the first insurance application is submitted by an agent, whichever is earlier, file with the commissioner a notice of appointment on a form or in a format prescribed by the commissioner.
  - (b) If there is no executed agent contract, the insurer shall also mail to the agent, within the same fifteen (15) day period specified in paragraph (a) of this subsection, a copy of the notice of appointment form filed with the commissioner.
- (6) (a) Within fifteen (15) days of receipt of the notice of appointment *of an agent*, the commissioner shall determine and notify the insurer whether the agent is eligible for appointment.
  - (b) If the agent's license is in good standing and no other grounds exist to deny the appointment, the commissioner shall approve the appointment.
- (7) Subject to renewal by the insurer as provided in subsection (8) of this section, each appointment *of an agent* shall remain in effect until the earliest of the following:
  - (a) The commissioner revokes or otherwise terminates the ~~agent's insurance producer's~~ license;
  - (b) The commissioner suspends, revokes, or otherwise terminates the appointment; or
  - (c) The insurer terminates the appointment as provided in KRS 304.9-280.
- (8) (a) Biennially, before January 31, the department shall distribute to each insurer a listing of the names and individual identification numbers of that insurer's agents whose appointments were in effect during the preceding calendar year and who were not terminated on or prior to December 31 of that calendar year.
  - (b) Any appointment not expressly terminated shall remain in effect as to the lines of authority thereof for which the respective agents are currently appointed, and subject to the fees specified under KRS 304.4-010.
  - (c) On or before March 31, each insurer shall submit the renewal of appointment fee as specified in KRS 304.4-010 for each appointment not terminated on or prior to December 31 of the preceding calendar year.
- (9) (a) Any appointment as to which the request for renewal and fees are not received by the commissioner by March 31 shall be deemed to have expired at midnight on March 31.
  - (b) Any appointment renewal request and fees received by the commissioner after March 31 and prior to the next following June 30 may be accepted by the commissioner, in his or her discretion, and the expired appointment may be reinstated as of March 31 if the late request and fees are accompanied by a penalty as provided in KRS 304.99-100.
- (10) *As used in this section, "agent" includes a managing general agent, a rental vehicle agent, and a rental vehicle agent managing employee.*

➔Section 20. KRS 304.9-295 is amended to read as follows:

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- (1) This section shall apply to individuals who hold licenses or lines of authority requiring continuing education each biennium.
- (2) The continuing education biennial compliance date for an individual resident licensee shall be as follows:
- (a) A licensee whose birth date is in an even-numbered year shall satisfy continuing education requirements on or before the last day of the licensee's birth month in the even-numbered year. A licensee shall show proof of compliance to the commissioner within sixty (60) days after the continuing education biennial compliance date. If the licensee has not held the license for one (1) year, the compliance date is adjusted to the next even-numbered year and each subsequent even-numbered year thereafter. If the license becomes inactive and reissued within a twelve (12) month period, the compliance date shall remain the same; *and*
  - (b) A licensee whose birth date is in an odd-numbered year shall satisfy continuing education requirements and show proof of compliance to the commissioner on or before the last day of the licensee's birth month in the odd-numbered year. A licensee shall show proof of compliance to the commissioner within sixty (60) days after the continuing education biennial compliance date. If the licensee has not held the license for one (1) year, the compliance date is adjusted to the next odd-numbered year and each subsequent odd-numbered year thereafter. If the license becomes inactive and reissued within a twelve (12) month period, the compliance date shall remain the same.
- (3) This section shall not apply to:
- (a) Limited lines of authority under agent licenses, as exempted by the commissioner in accordance with KRS 304.9-230;
  - (b) Licensees not licensed for one (1) full year prior to the end of the applicable continuing education biennium;
  - (c) Licensees holding nonresident licenses who have met the continuing education requirements of their home state and whose home state gives credit to Kentucky resident licensees on the same basis; or
  - (d) Licensees maintaining their licenses for the sole purpose of receiving renewals or deferred commissions and providing the department with a supporting affidavit.
- (4) A licensee, who holds an agent license and who is not exempt under subsection (3) of this section, shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, of which three (3) hours shall have a course concentration in ethics, during each continuing education biennium.
- (5) ~~(a) Beginning July 31, 2012, an individual who holds an independent or public adjuster license, including a nonresident independent or public adjuster that designates Kentucky as his or her home state, and who is not exempt under KRS 304.9-430(10) or (11), shall satisfactorily complete a minimum of twenty-four (24) hours of continuing education courses, of which three (3) hours shall have a course concentration in ethics in accordance with subsection (4) of this section.~~
- (b) Continuing education hours shall be reported to the commissioner on a biennial basis in conjunction with the licensee's renewal in accordance with subsection (10) of this section.
- (6) (a) Only continuing education courses approved by the commissioner shall be used to satisfy the continuing education ~~requirements~~~~requirement~~ of ~~subsection (4) of~~ this section and any other continuing education requirement of this chapter.
- ~~(b)(a)~~ The continuing education courses which meet the commissioner's standards for continuing education requirements are:
1. Any part of the Life Underwriter Training Council life course curriculum;
  2. Any part of the Health Underwriter Training Council health course curriculum;
  3. Any part of the American College Chartered Life Underwriter diploma curriculum;
  4. Any part of the American Institute for Property and Liability Underwriters' chartered property and casualty underwriter profession designation program;
  5. Any part of the Insurance Institute of America's programs;
  6. Any part of the certified insurance counselor program;

7. Any insurance related course taught at an accredited college or university, if the course is approved by the commissioner;
  8. Any course of instruction or seminar developed or sponsored by any authorized insurer, recognized agent association, recognized insurance trade association, or any independent program of instruction, if approved by the commissioner;
  9. Any correspondence course approved by the commissioner; and
  10. Any course in accordance with provisions of reciprocal agreements the commissioner enters with other states.
- ~~(c)~~~~(b)~~ **1.** The commissioner shall prescribe the number of hours of continuing education credit for each continuing education course approved in accordance with this subsection.
- 2.** Continuing education courses submitted in accordance with a reciprocal agreement shall be approved according to the provisions of the reciprocal agreement.
- ~~(d)~~~~(e)~~ If a continuing education course requires successful completion of a written examination, no continuing education credit shall be given to licensees who do not successfully complete the written examination.
- ~~(e)~~~~(d)~~ The fee for filing continuing education courses for approval by the commissioner shall be as specified in Subtitle 4 of KRS Chapter 304.
- ~~(f)~~~~(e)~~ For continuing education courses of reciprocal states, continuing education providers shall be approved in accordance with the provisions of the reciprocal agreements.
- (7) An individual teaching any ~~approved~~ continuing education course ***approved by the commissioner*** shall qualify for the same number of hours of continuing education credit as would be granted to a licensee taking and satisfactorily completing the course.
  - (8) Excess credit hours accumulated during any continuing education biennium may be carried forward. The commissioner may, by ***administrative*** regulation, limit the number of hours carried forward.
  - (9) **(a)** For good cause shown, the commissioner may grant an extension of time during which the continuing education requirement of subsection (2) of this section may be completed, but the extension of time shall not exceed two (2) years.
  - (b)** What constitutes good cause for the extension of time rests within the discretion of the commissioner.
  - (10) **(a)** Every licensee subject to this section shall furnish to the commissioner written certification as to the continuing education courses satisfactorily completed by the licensee.
  - (b)** The certification shall:
    - 1.** Be signed by or on behalf of the provider sponsoring the continuing education course; ***and***
    - 2.** ***Contain an attestation signed by the licensee.***
  - (c)** The certification shall be on a form prescribed by the commissioner.
  - (d)** ***A licensee is responsible for ensuring that a certification submitted by the licensee under this subsection:***
    - 1.** ***Contains the correct license identification number; and***
    - 2.** ***Is applied to the licensee's license record.***
  - (11) **(a)** The provider shall furnish to the commissioner certification as to the continuing education courses satisfactorily completed by each licensee.
  - (b)** The certification shall be signed or authenticated by or on behalf of the provider sponsoring the continuing education course.
  - (c)** The certification shall be on a form or in a format prescribed by the commissioner.
  - (12) The license or line of authority requiring continuing education shall expire if the individual holding the license or line of authority:

- (a) Fails to comply with the continuing education requirement; and
  - (b) Has not been granted an extension of time to comply in accordance with subsection (9) of this section. ~~If the license has expired, the license shall be promptly surrendered to the commissioner without demand. If the line of authority has terminated but another line of authority not requiring continuing education is still in effect, the license shall be promptly delivered to the commissioner for reissuance as to the line of authority still in effect.~~
- (13) ~~The license of any individual subject to the continuing education requirement shall be suspended or revoked, a civil penalty imposed, or both, in accordance with KRS 304.9-440, if an individual submits to the commissioner a false or fraudulent certification certificate of compliance with a continuing education requirement, the commissioner shall, in accordance with KRS 304.9-440, suspend or revoke the license of the individual, impose a civil penalty, or both.~~
- (14) (a) The commissioner may withdraw approval of a continuing education provider, course, or instructor for good and just cause.
- (b) In addition to or in lieu of withdrawal of approval, the commissioner may impose a civil penalty of not more than one thousand dollars (\$1,000) per violation of this chapter by a provider or an instructor.

➔SECTION 21. KRS 304.9-436 IS REPEALED AND REENACTED TO READ AS FOLLOWS:

*An authorized insurer shall not do business in Kentucky with a person that is unlicensed in violation of this subtitle.*

➔Section 22. KRS 304.13-346 is amended to read as follows:

- (1) As used in this section:
- (a) "Cost to upgrade the single-family dwelling" means the cost required to upgrade the **roof structure of the** single-family dwelling to meet or exceed ~~the construction standards required for the dwelling to comply with~~ the most recent version of ~~the any applicable~~ FORTIFIED Home **roof structure** construction standards published by the Insurance Institute for Business and Home Safety or a successor entity; and
  - (b) "Non-FORTIFIED dwelling" means a dwelling **whose roof structure** ~~that~~ does not comply with the most recent version of ~~the any applicable~~ FORTIFIED Home **roof structure** construction standards published by the Insurance Institute for Business and Home Safety or a successor entity.
- (2) All insurance companies writing property insurance for personal risks that provides coverage of any single-family dwelling located in Kentucky that is a non-FORTIFIED dwelling shall offer an optional rider, endorsement, or supplemental policy provision that provides the insured a right to receive claim payments for the cost to upgrade the single-family dwelling for any claim that:
- (a) Is covered under the insurance policy or contract; and
  - (b) Requires replacement of the covered dwelling's roof as defined by the insurance policy or contract.

➔Section 23. KRS 304.14-120 is amended to read as follows:

- (1) (a) Except as otherwise provided in this section, a basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or printed rider or indorsement form or form of renewal certificate, shall not be delivered, or issued for delivery in this state, unless the form has been filed with and approved by the commissioner.
- (b) This subsection shall not apply to:
1. Any rates filed under Subtitle 17A of this chapter;
  2. Surety bonds;
  3. Specially rated inland marine risks; or
  4. Policies, riders, indorsements, or forms of unique character:
    - a. Designed for and used with relation to insurance upon a particular subject; or
    - b. Which relate to the manner or distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder.

- (c) As to group insurance policies issued and delivered to an association outside this state but covering persons resident in this state, all or substantially all of the premiums for which are payable by the insured members, the group certificates to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner.
- (d) 1. As to forms for use in property, *inland* marine ~~(other than wet marine and transportation insurance)~~, casualty, and surety insurance coverages (other than accident and health), the filing required by this subsection may be made by advisory organizations or form providers on behalf of their members and subscribers.
  - 2. This paragraph shall not be construed to prohibit any member or subscriber of an advisory organization or form provider from filing any forms on its own behalf.
- (e) Every advisory organization and form provider shall file with the commissioner for approval every property and casualty policy form and endorsement before distribution to members, subscribers, customers, or others.
- (f) Every property and casualty insurer shall file with the commissioner notice of adoption before use of any approved form filed by an advisory organization or form provider or filed by the insurer pursuant to paragraph (d) of this subsection.
- (2) (a) Every filing required under this section shall be made not less than sixty (60) days in advance of any delivery of the form in this state.
  - (b) At the expiration of sixty (60) days, the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the commissioner.
  - (c) Approval of any filing by the commissioner under this section shall constitute a waiver of any unexpired portion of the waiting period established under this subsection.
  - (d) The commissioner may extend the waiting period established under paragraph (a) of this subsection by not more than a thirty (30) day period, within which time he or she may affirmatively approve or disapprove any filing, by giving notice to the insurer of the extension before expiration of the initial sixty (60) day period.
  - (e) At the expiration of any period extended under paragraph (d) of this subsection, and in the absence of a prior affirmative approval or disapproval, the filing shall be deemed approved.
  - (f) The commissioner may at any time, after notice and for cause shown, withdraw approval of any filing.
- (3) (a) Any order of the commissioner disapproving any filing, or any notice of the commissioner withdrawing a previous approval, shall state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer.
  - (b) Any withdrawal of a previously approved filing shall be effective not less than thirty (30) days after the insurer receives notice of the withdrawal, as the commissioner shall in such notice prescribe.
- (4) Except as provided in subsection (6) of this section, the commissioner may, by order, exempt from the requirements of this section, for so long as he or she deems proper, any insurance document or form or type thereof, as specified in the commissioner's order, to which, in his or her opinion:
  - (a) This section may not practicably be applied; or
  - (b) The filing and approval of are not desirable or necessary for the protection of the public.
- (5) Appeals from orders of the commissioner disapproving any filing or withdrawing a previous approval shall be taken as provided in Subtitle 2 of this chapter.
- (6) The commissioner shall:
  - (a) Review every filing relating to a health plan, as defined in KRS 304.17A-591, for compliance with KRS 304.17A-591 to 304.17A-599; and
  - (b) Not approve any filing referenced in paragraph (a) of this subsection that does not comply with KRS 304.17-591 to 304.17A-599.
- (7) As used in this section, unless the context requires otherwise:

- (a) "Advisory organization" has the same meaning as in KRS 304.13-011; and
- (b) "Form provider" has the same meaning as in KRS 304.13-011.

➔Section 24. KRS 304.15-365 is amended to read as follows:

- (1) This section shall be known as the "Standard Nonforfeiture Law for Individual Deferred Annuities of 2005."
- (2)
  - (a) This section shall not apply to any reinsurance group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the insurer issuing the contract.
  - (b) However, to the extent that a variable annuity contract provides benefits that do not, before the maturity date, vary in accordance with the investment performance of any separate account or accounts maintained by the insurer as to such contract, as provided for in KRS 304.15-390, the contract shall contain provisions that satisfy the requirements of this section and shall not otherwise be subject to this section.
- (3)
  - (a) In the case of contracts issued on or after July 1, 2006, no contract of annuity, except as provided in subsection (2) of this section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:
    - 1.~~{(a)}~~ That upon cessation of payment of considerations under a contract, or upon the written request of the contract owner, the insurer shall grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in subsections (8), (9), (10), (11), and (13) of this section;
    - 2.~~{(b)}~~ If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the insurer shall pay, in lieu of any paid-up annuity benefit, a cash surrender benefit of such amount as is specified in subsections (8), (9), (10), (11), and (13) of this section. The insurer may reserve the right to defer the payment of this cash surrender benefit for a period not to exceed six (6) months after demand therefor with surrender of the contract after making written request and receiving written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;
    - 3.~~{(c)}~~ A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits; and
    - 4.~~{(d)}~~ A statement that any paid-up annuity, cash surrender or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which these benefits are altered by the existence of any additional amounts credited by the insurer to the contract, any indebtedness to the insurer on the contract, or any prior withdrawals from or partial surrenders of the contract.
  - (b) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to that period would be less than twenty dollars (\$20) monthly, the insurer may at its option terminate the contract by payment in cash of the then-present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by this payment shall be relieved of any further obligation under such contract.
- (4)
  - (a) The minimum values as specified in subsections (8), (9), (10), (11), and (13) of this section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

- ~~(b)(a)~~ The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest as indicated in subsection (5) of this section of the net considerations, as defined in paragraph ~~(c)(b)~~ of this subsection, paid prior to that time, decreased by the sum of:
1. Any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest as indicated in subsection (5) of this section;
  2. An annual contract charge of fifty dollars (\$50) accumulated at rates of interest as indicated in subsection (5) of this section; and
  3. The amount of any indebtedness to the insurer on the contract, including interest due and accrued.
- ~~(c)(b)~~ The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87.5%) of gross considerations credited to the contract during that contract year.
- (5) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:
- (a) The five (5) year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date or average over a period rounded to the nearest one-twentieth of one percent (0.05%), specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under paragraph (d) of this subsection;
  - (b) Reduced by one hundred twenty-five (125) basis points;
  - (c) Where the resulting interest rate is not less than one percent (1%); and
  - (d) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five (5) year Constant Maturity Treasury Rate to be used at each redetermination date.
- (6) *(a)* During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (5)(b) of this section up to an additional one hundred (100) basis points to reflect the value of the equity index benefit.
- (b)* The present value at the contract issue date and at each redetermination date thereafter of the additional reduction shall not exceed the market value of the benefit.
- (c)* The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.
- (d)* Lacking such demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.
- (7) The commissioner may promulgate administrative regulations in accordance with KRS Chapter 13A *that*:
- (a)* **Implement**~~Implementing~~ the provisions of subsection (6) of this section; and
  - (b)* ~~To~~ Provide for further adjustments to the calculation of minimum nonforfeiture amounts for:
    1. Contracts that provide substantive participation in an equity index benefit; and~~for~~
    2. Other contracts for which the commissioner determines adjustments are justified.
- (8) *(a)* Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.
- (b)* This present value shall be computed using the mortality table, if any, and the interest rates specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.
- (9) *(a)* For contracts which provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity

arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, the present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, decreased by the amount of any indebtedness to the insurer on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the insurer to the contract.

- (b) In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time.
  - (c) The death benefit under the contracts shall be at least equal to the cash surrender benefit.
- (10) (a) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, the present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the insurer to the contract.
- (b) For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.
  - (c) However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.
- (11) For the purpose of determining the benefits calculated under subsections (9) and (10) of this section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.
- (12) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.
- (13) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.
- (14) (a) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract.
- (b) Notwithstanding the provisions of subsections (8), (9), (10), (11), and (13) of this section, additional benefits payable:
    1. ~~(a)~~ In the event of total and permanent disability;
    2. ~~(b)~~ As reversionary annuity or deferred reversionary annuity benefits; or
    3. ~~(c)~~ As other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits;

shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits that may be required by this section. The inclusion of these additional benefits shall not be required in any paid-up benefits, unless these additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.
- (15) *Any optional maturity date offered for an annuity contract issued pursuant to this section shall:*

- (a) *Not impose a surrender charge that is longer than ten (10) years beyond the optional maturity date agreed to by the annuitant and the insurer; and*
- (b) *Be offered to an annuitant before the annuitant attains seventy (70) years of age.*

~~(16)(15)~~ (a) After August 1, 2005, any insurer may file with the commissioner a written notice of its election to apply the provisions of this section on a contract-form by contract-form basis to annuity contracts issued by the insurer during the period from the date of the election through June 30, 2006.

(b) Insurers shall apply the provisions of this section to annuity contracts issued on or after July 1, 2006.

➔Section 25. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) ~~{(a)}~~ "Adverse *benefit* determination":

(a) *Has the same meaning as in 29 C.F.R. sec. 2560.503-1, as amended; and*

(b) *Includes:*

1. ~~{means}~~ A determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

a. ~~{}~~ Not medically necessary, as determined by the insurer~~{,}~~ or its designee; or

b. Experimental or investigational, as determined by the insurer~~{,}~~ or its designee; and

2. *A coverage denial*~~{Benefit coverage is therefore denied, reduced, or terminated.}~~

~~(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;~~

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) *"Coverage denial" means a determination that a service, procedure, treatment, drug, supply, or device is specifically limited or excluded under a covered person's health benefit plan;*

~~(5){(4)}~~ "Covered person" means a person covered under a health benefit plan;

~~(6){(5)}~~ "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in *Section 29 of this Act and* KRS 304.17A-623, 304.17A-625, and 304.17A-627;

~~(7){(6)}~~ "Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of KRS 304.17A-600 to 304.17A-633, the term includes short-term coverage policies;

~~(8){(7)}~~ "Independent review entity" means an individual or organization certified by the department to perform external reviews under *Section 29 of this Act and* KRS 304.17A-623, 304.17A-625, and 304.17A-627;

~~(9){(8)}~~ "Insurer" means any of the following entities ~~that authorized to~~ *or provide* health benefit plans~~{ as defined in subsection (6) of this section}~~:

(a) An insurance company;~~{}~~

(b) Health maintenance organization;

(c) Self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA;

(d) Provider-sponsored integrated health delivery network;

(e) Self-insured employer-organized association;

(f) Nonprofit hospital, medical-surgical, or health service corporation; or

(g) Any other entity authorized to transact health insurance business in Kentucky;

- (10)~~(9)~~ "Internal appeals process" means a formal *appeals* process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or *private review* agent ~~whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent~~;
- (11)~~(10)~~ "Nationally recognized accreditation organization":
- (a) Means a private nonprofit entity that:
    1. Sets national utilization review and internal appeal standards; and
    2. Conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification; and
  - (b) Shall include the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission, or any other organization identified by the department;
- (12)~~(11)~~ "Private review agent" or "agent":
- (a) Means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth; and
  - (b) Does not include an independent review entity *that*~~which~~ performs external *reviews*~~review of adverse determinations~~;
- (13)~~(12)~~ "Prospective review":
- (a) Means a utilization review that is conducted prior to the provision of health care services; ~~and~~ ~~"Prospective review" also~~;
  - (b) Includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy protocol, preadmission review, pretreatment review, utilization, and case management;
- (14)~~(13)~~ "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;
- (15)~~(14)~~ "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review;
- (16)~~(15)~~ "Retrospective review":
- (a) Means utilization review that is conducted after health care services have been provided to a covered person; and
  - (b) Does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;
- (17)~~(16)~~ ~~{(a)—}~~"Urgent health care services":
- (a) Means health care or treatment with respect to which the application of the time periods for making a nonurgent determination:
    1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
    2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; ~~and~~ ~~—~~
  - (b) ~~Includes~~~~Urgent health care services include~~ all requests for hospitalization and outpatient surgery;
- (18)~~(17)~~ "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review; and

~~(19)~~~~(18)~~ "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

→ Section 26. KRS 304.17A-607 is amended to read as follows:

- (1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department.
- (2) A registered insurer or private review agent shall:
  - (a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;
  - (b) Ensure that, ~~for any contract entered into on or after January 1, 2020,~~ for the provision of utilization review services, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall:
    1. Make a utilization review decision to:
      - a. Deny, reduce, limit, or terminate a health care benefit; or ~~to~~
      - b. Deny, or reduce payment for, a health care service because that service is not medically necessary, experimental, or investigational;
 

except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and
    2. Supervise qualified personnel conducting case reviews;
  - (c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;
  - (d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. ~~pts.~~~~secs.~~ 160 to 164 and other applicable laws and administrative regulations;
  - (e) Provide a toll-free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;
  - (f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;
  - (g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse **benefit** determinations ~~and coverage denials~~ of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;
  - (h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, or as otherwise provided in this subtitle, provide a utilization review decision in accordance with the timeframes in paragraph (i) of this subsection and 29 C.F.R. ~~pt.~~~~Part~~ 2560, including written notice of the decision;
  - (i)
    1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and
    2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information to make the utilization review decision.

For purposes of this paragraph, "necessary information" is limited to:

- a. The results of any face-to-face clinical evaluation;

- b. Any second opinion that may be required; and
  - c. Any other information determined by the department to be necessary to making a utilization review determination;
- (j) **1.** Provide written notice of review decisions to the covered person, authorized person, and providers.
- 2.** The written notice may be provided in an electronic format, including email or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically.
- 3.** An insurer or agent that denies a step therapy exception, as defined in KRS 304.17A-163, or denies coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:
- ~~a.1.~~ A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
  - ~~b.2.~~ The title of the reviewer making the decision, except that a written notice provided to a provider shall also include, *if applicable*, the medical license number of the reviewer making the decision;
  - ~~c.3.~~ Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
  - ~~d.4.~~ Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum:~~;~~
    - ~~i.~~ Whether the appeal shall be in writing;~~;~~ ~~and~~
    - ~~ii.~~ Any specific filing procedures, including any applicable time limitations or schedules;~~;~~ and
    - ~~iii.~~ The position and phone number of a contact person who can provide additional information;
- (k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and
- (l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.
- ~~(3)(2)~~ **(a)** The insurer's or private review agent's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be a prior authorization for the health care services or benefits subject to the review.
- (b)** This ~~subsection~~~~provision~~ shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.
- ~~(4)(3)~~ **(a)** An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department.
- (b)** No change to *utilization review* policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.
- ~~(5)(4)~~ **(a)** A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state.
- (b)** Notice shall be provided *to the department* within thirty (30) days of any change.
- ➔Section 27. KRS 304.17A-617 is amended to read as follows:
- (1) (a) Every insurer shall have an internal appeal process *for adverse benefit determinations that is:*

1. ~~{to be}~~ Utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619; and ~~{which shall be}~~
  2. Disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).
- (b) An insurer shall disclose the availability of the internal **appeal** process to the covered person in the insured's timely notice of an adverse **benefit** determination ~~{or notice of a coverage denial}~~ which meets the requirements in KRS 304.17A-607(2) ~~{(1)}~~ (j).
  - (c) ~~{For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.}~~
  - ~~(d)~~ Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.
- (2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person.
  - (3) The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse **benefit** determinations ~~{made under utilization review and of coverage denials}~~, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review.
  - (4) At a minimum, ~~the~~ ~~{these}~~ procedures **required under subsection (3) of this section** shall include the following:
    - (a) Except as provided in KRS 304.17A-163, ~~{~~
      - ~~1.~~ ~~{~~ insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals: ~~{of adverse determinations or coverage denials}~~
      1. Within thirty (30) days of receipt of the request for internal appeal, **except as provided in subparagraph 2. of this paragraph; or** ~~{and}~~
      2. ~~{Insurers or their designees shall render a decision}~~ Not later than three (3) business days after receipt of ~~a~~ ~~{the}~~ request for an expedited appeal of ~~{either}~~ an adverse **benefit** determination ~~{or a coverage denial}~~. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:
        - a. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
        - b. Serious impairment to bodily functions; or
        - c. Serious dysfunction of a bodily organ or part;
    - (b) Internal appeal of an adverse **benefit** determination, **other than a coverage denial**, shall only be conducted by a licensed physician who did not participate in the initial review and denial, **except** ~~{However,}~~ in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board-eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;
    - (c) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information; and
    - (d) In addition to any previous notice required under KRS 304.17A-607(2) ~~{(1)}~~ (j), and to facilitate expeditious handling of a request for external review ~~{of an adverse determination}~~ or **review of a coverage denial under subsection (5) of this section**, an insurer or agent that denies, limits, reduces, or terminates coverage for a **service**, treatment, procedure, drug, **supply**, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that **includes** ~~{shall include}~~:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
  2. *As applicable*, the state of licensure and the title of the person making the decision, except that an internal appeal determination letter provided to a provider acting on behalf of the covered person shall also include the medical license number of the person making the decision;
  3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
  4. Instructions for:
    - a. Initiating an external review;~~[of an adverse determination,] or~~
    - b. *For coverage denials*, filing a request for review with the department *under subsection (5) of this section*~~[if a coverage denial is upheld by the insurer on internal appeal].~~
- (5)~~(4)~~
- (a) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers.
  - (b) For purposes of this subsection, "coverage denials" shall not include~~[an adverse determination as defined in KRS 304.17A-600 or]~~ subsequent denials arising from an adverse *benefit* determination *that is not a coverage denial*.
  - (c) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall:
    1. Notify the insurer *that*~~[which]~~ issued the denial of the request for review; and~~[shall]~~
    2. Call for the insurer to respond to the department regarding the request for review within ten (10) business days of receipt of notice to the insurer.
  - (d) Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:
    1. Confirmation as to whether the person who received or sought the~~[health]~~ service, *procedure, treatment, drug, supply, or device* for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service, *procedure, treatment, drug, supply, or device* was sought or denied;
    2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's *internal* appeal process under this section; and
    3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.
  - (e) In addition to the information described in paragraph (d) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review.
  - (f)
    1. On the receipt of the information described in paragraphs (d) and (e) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, *procedure, treatment, drug, supply, or device* is specifically limited or excluded under the terms of the covered person's health benefit plan.
    2. If the department determines that the *service, procedure, treatment, [service,] drug, supply, or device* is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, *procedure, treatment, drug, supply, or device* or afford the covered person an opportunity for external review~~[under KRS 304.17A-621, 304.17A-623, and 304.17A-625], where the conditions precedent to the review are present.~~
    3. If the department notifies the insurer that the *service, procedure, treatment, [service,] drug, supply, or device* is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service, *procedure, treatment, drug, supply, or device* or afford the covered person an external review.

- (g) An insurer shall be required to cover the **service, procedure**, treatment,~~[service,]~~ drug, **supply**, or device that was denied or provide notification of the right to external review in accordance with paragraph (f) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.
- (h) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the **service, procedure**, treatment,~~[service,]~~ drug, **supply**, or device that was denied for a period not to exceed thirty (30) days or provide the covered person the opportunity for external review.

➔Section 28. KRS 304.17A-619 is amended to read as follows:

- (1) (a) If the covered person, authorized person, or provider has new clinical information regarding the covered person's internal appeal, he or she shall provide that information to the insurer prior to the initiation of the external review process.
- (b) The insurer shall have five (5) business days from the date of the receipt of the information to render a decision based on the new information.
- (c) If new information is provided in accordance with this **subsection**~~[section]~~, the sixty (60) day time frame for commencing an external review as set forth in KRS 304.17A-623(4), shall not begin to run, until the insurer or its designee renders a decision regarding the new information.
- (2) The insurer's failure to make a determination or provide a written notice within the time frames set forth in KRS 304.17A-617 shall be deemed to be an adverse **benefit** determination, **other than a coverage denial**, by the insurer for the purpose of initiating an external review as set forth in KRS 304.17A-623.

➔Section 29. KRS 304.17A-621 is amended to read as follows:

The Independent External Review Program is hereby established in the department. The program shall provide covered persons with a formal, independent review to address disagreements between the covered person and the covered person's insurer~~[regarding an adverse determination made by the insurer, its designee, or a private review agent]~~. This section and KRS 304.17A-623,~~[and]~~ 304.17A-625, **and 304.17A-627** establish requirements and procedures governing external review and independent review entities.

➔Section 30. KRS 304.17A-623 is amended to read as follows:

- (1) (a) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).
- (b) An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse **benefit** determination, **other than**~~[or notice of]~~ a coverage denial, as set forth in KRS 304.17A-607(2)~~(1)~~(j) and in the denial letter required in KRS 304.17A-617(1) and ~~(4)~~~~(3)~~(d).~~†~~
- ~~(c) For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.~~
- (2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse **benefit** determination, **other than a coverage denial**, rendered by an insurer, its designee, or agent.
- (3) Except as provided in KRS 304.17A-163, the insurer shall provide~~[for]~~ an external review~~[of an adverse determination]~~ if the following criteria are met:
  - (a) The insurer, its designee, or agent has rendered an adverse **benefit** determination, **other than a coverage denial**;
  - (b) The covered person has completed the insurer's internal appeal process~~[,]~~ or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may, however, jointly agree to waive the internal appeal requirement;
  - (c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed **health care** service was requested; and

- (d) The entire course of treatment or service will cost the covered person at least one hundred dollars (\$100) if the covered person had no insurance.
- (4) (a) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse *benefit* determination, *other than a coverage denial*, has been timely rendered under the insurer's internal appeal process.
- (b) As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the *determination*~~decision to deny, limit, reduce or terminate coverage~~.
- (5) (a) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars (\$25) *that*:
1. ~~Shall~~ be paid to the independent review entity; and ~~which~~
  2. May be waived if the independent review entity determines that the fee creates a financial hardship on the covered person.
- (b) The fee shall be refunded if the independent review entity finds in favor of the covered person.
- (6) A covered person shall not be afforded an external review~~of an adverse determination~~ if:
- (a) The subject of the covered person's *external review request*~~adverse determination~~ has previously gone through the external review process and the independent review entity found in favor of the insurer; and
  - (b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.
- (7) (a) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews.
- (b) The system established by the department shall:
1. Be prospective; and ~~shall~~
  2. Require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews.
- (c) The department shall contract with no less than two (2) independent review entities.
- (8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department.
- (b) Within five (5) days of receipt of the complaint, the department:
1. Shall render a decision; and
  2. May direct the insurer to submit the dispute to an independent review entity for an external review if it finds:
    1. ~~The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and~~
    2. ~~all of the requirements of subsection (3) of this section have been met.~~
- (c)~~(b)~~ The complaint process established in this section shall:
1. Be separate and distinct from, and ~~shall~~ in no way limit, other grievance or complaint processes available to consumers under other provisions of the *Kentucky Revised Statutes*~~KRS~~ or duly promulgated administrative regulations; ~~and~~~~This complaint process shall~~
  2. Not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.
- (9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.
- (10) External reviews shall be conducted in an expedited manner by the independent review entity if:
- (a) The covered person is hospitalized;~~;~~ or ~~if;~~

- (b) In the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:
  - 1.~~(a)~~ Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;
  - 2.~~(b)~~ Serious impairment to bodily functions; or
  - 3.~~(c)~~ Serious dysfunction of a bodily organ or part.
- (11) Requests for expedited external review~~[-]~~ shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.
- (12) (a) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the insurer.
  - (b) An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree.
  - (c) The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the **external review request**~~[adverse determination]~~ has been assigned to an independent review entity for expedited review.
- (13) (a) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days from the receipt of all information required from the insurer.
  - (b) An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

➔Section 31. KRS 304.17A-625 is amended to read as follows:

- (1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:
  - (a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:
    - 1. The covered person's medical records;
    - 2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and
    - 3. The insurer's health benefit plan;
  - (b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services, and the Agency for Health Care Research and Quality; and
  - (c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies.
- (2) (a) The independent review entity shall base its decision on the information submitted under subsection (1) of this section.
  - (b) In making its decision, the independent review entity shall consider safety, appropriateness, and cost effectiveness.
- (3) (a) The insurer shall provide any coverage determined by the independent review entity to be medically necessary.
  - (b) The independent review entity shall not be permitted to allow coverage for **a service, procedure, treatment, drug, supply, or device that is**~~[services]~~ specifically limited or excluded by the insurer in its health benefit plan.
  - (c) The decision shall apply only to the individual covered person's external review.

- (4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in KRS 304.17A-515(1)(c) and 304.17A-550.
- (5) The insurer shall be responsible for the cost of the external review.
- (6) The independent review entity shall provide to the covered person, treating provider, insurer, and the department a decision which shall include:
- (a) The findings for either the insurer or covered person regarding each issue under review;
  - (b) The proposed service, *procedure*, treatment, drug, device, or supply for which the review was performed;
  - (c) The relevant provisions in the insurer's health benefit plan and how applied; and
  - (d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.
- (7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.
- (8) (a) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the ~~insurer's~~ ~~{adverse}~~ determination.
- (b) The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.
- (9) (a) The decision of the independent review entity shall be binding on the insurer with respect to that covered person.
- (b) Failure of the insurer to provide coverage as required by the independent review entity shall:
1. ~~{(a)}~~ Be a violation of the insurance code of a nature sufficient to warrant the commissioner revoking or suspending the insurer's license or certificate of authority; and
  2. ~~{(b)}~~ Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.
- (10) (a) Failure to provide coverage as required by the independent review entity shall also:
1. Subject the insurer to the provisions of KRS 304.99-010 and 304.99-020; and
  2. Require the insurer to pay the claim that was the subject of the external review, without need for the covered person or authorized person to further establish a right as to the payment amount.
- (b) Reasonable ~~attorney's~~ ~~{attorney}~~ fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.
- (11) The insurer shall implement the decision of the independent review entity whether the covered person has disenrolled or remains enrolled with the insurer.
- (12) If the covered person has been disenrolled with the insurer, the insurer shall only be required to provide the treatment, *procedure*, service, drug, *supply*, or device that was previously denied by the insurer, its agent, or designee and later approved by the independent review entity for a period not to exceed thirty (30) days.
- (13) Within thirty (30) days of the decision in favor of the covered person by the independent review entity, the insurer shall provide written notification to the department that the decision has been implemented in accordance with this section.
- (14) (a) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review.
- (b) This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in KRS 304.17A-621, 304.17A-623, and 304.17A-625.
- (15) Nothing in KRS 304.17A-600 to 304.17A-633 shall be construed to create a cause of action against any of the following:
- (a) An employer that provides health care benefits to employees through a health benefit plan;

- (b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review addressed in KRS 304.17A-600 to 304.17A-633; or
  - (c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.
- (16) (a) The covered person, insurer, or provider in the external review may submit written complaints to the department regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.
- (b) The department shall promptly review the complaint, and if the department determines that the actions of the independent review entity were inappropriate, the department shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews.
- (c) The department's actions shall be subject to the powers and administrative procedures set forth in Subtitle 17A of KRS Chapter 304.

➔Section 32. KRS 304.99-020 is amended to read as follows:

- (1) For any violation of this code where the commissioner has the power to revoke or suspend a license or certificate of authority, the commissioner may in lieu thereof or in addition to such revocation or suspension impose a civil penalty against the violator ***of not more than the following:***
- (a) In the case of an insurer, a fraternal benefit society, nonprofit hospital, medical-surgical, dental, and health service corporation, or health maintenance organization, ~~of not more than~~ ten thousand dollars (\$10,000) per violation;
  - (b) In the case of an agent, surplus lines broker, rental vehicle agent, ~~or~~ ***rental vehicle agent*** managing employee, ~~specialty credit producer or managing employee,~~ or reinsurance intermediary broker or manager, ~~of not more than~~ one thousand dollars (\$1,000) per violation; ***and***
  - (c) In the case of an adjuster, administrator, life settlement broker, life settlement provider, or consultant, ~~of not more than~~ two thousand dollars (\$2,000) per violation.
- (2) ***The civil penalties authorized under subsection (1) of this section*** ~~Such civil penalty~~ may be recovered in an action brought ~~thereon~~ in the name of the Commonwealth of Kentucky in any court of appropriate jurisdiction.
- (3) In any court action with respect to a civil penalty, the court may review the penalty as to both liability and reasonableness of amount.

➔Section 33. KRS 304.99-100 is amended to read as follows:

- (1) The appointment of an agent, including ***a*** rental vehicle agent ***and*** ~~rental vehicle agent~~ ***agent*** managing employee, ~~specialty credit producer, and specialty credit managing employee,~~ may be renewed by an insurer under KRS 304.9-270(9) if the request and late payment for renewal is accompanied by a penalty equal to the amount of the biennial renewal fee specified in Subtitle 4 of this chapter.
- (2) A license issued under Subtitle 9 of this chapter, surplus lines broker license, life settlement broker license, and life settlement provider license may be reissued under KRS 304.9-260(2) if the request and late payment for reissue are accompanied by a penalty equal to the amount of the biennial renewal fee specified in Subtitle 4 of this chapter.

➔Section 34. Whereas the availability of certified and approved building contractors is crucial to ensuring that Kentucky homes are mitigated to resist future losses due to catastrophic wind and hail events, an emergency is declared to exist, and Section 5 of this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.

**Signed by Governor April 7, 2026.**