

806 KAR 17:190. Guaranteed Acceptance Program requirements.

RELATES TO: KRS 304.17A-210(5)(b), 304.17A-420, 304.17A-430

STATUTORY AUTHORITY: KRS 304.2-110, 304.17A-210(5)(b), 304.17A-430

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110 authorizes the commissioner to promulgate administrative regulations to implement the Insurance Code. KRS 304.17A-210(5)(b) requires the commissioner to promulgate administrative regulations establishing equitable enrollment limits for new market insurers for the first twelve (12) months and a remaining portion of the calendar year after expiration of a twelve (12) month period. This administrative regulation establishes the limits and requirements of a new market insurer.

Section 1. Definitions. (1) "Alternative underwriting mechanism" or "AUM" is defined in KRS 304.17A-430(3).

(2) "Commissioner" is defined by KRS 304.1-050

(3) "GAP health benefit plan" means a health benefit plan issued to an individual with a high-cost condition or to an individual meeting the AUM criteria.

(4) "GAP participant" means a GAP qualified individual defined in KRS 304.17A-005(15) who has been issued a GAP health benefit plan.

(5) "GAP participating insurer" is defined by KRS 304.17A-005(12).

(6) "GAP qualified individual" is defined by KRS 304.17A-005(15).

(7) "Guaranteed Acceptance Program" or "GAP" is defined in KRS 304.17A-005(14).

(8) "High-cost condition" is defined by KRS 304.17A-005(19).

(9) "Mandatory GAP participating insurer" means a health insurer in Kentucky that has twenty-five (25) percent or more of the market share and is required to be a GAP participating insurer.

(10) "New market insurer" means an insurer that enters the individual health market as a voluntary GAP participating insurer in Kentucky on or after July 1, 1998.

(11) "New market period" means a period extending twelve (12) months from the date a new market insurer enters the individual health insurance market in Kentucky, and includes the remainder of the calendar year after the twelve (12) month period expires.

(12) "Voluntary GAP participating insurer" means a health insurer that has less than twenty-five (25) percent of the market share and elects to be a GAP participating insurer.

Section 2. GAP Participating Insurer Requirements. A GAP insurer shall notify the commissioner of the effective date for GAP participation in writing with the following information:

(1) Name of the GAP health benefit plan;

(2) Product type of the health benefit plan;

(3) Geographic service area of the GAP health benefit plan;

(4) Cost containment features required in KRS 304.17A-450; and

(5) Any modification made to an existing health benefit plan to qualify it as a GAP health benefit plan.

Section 3. Enrollment Limits for a GAP Participating Insurer. (1) For the first three (3) months that a new market insurer enters the individual market, the insurer may not enroll any individuals in GAP.

(2) At the end of the first three (3) months that a new market insurer enters the individual market, the new market insurer shall have a GAP enrollment limit of one-half (1/2) of one (1) percent of its quarterly enrollment of the individual market projected until the end of the new market period.

(3) If, in the second three (3) month period after the new market insurer enters the individual market, the new market insurer meets the enrollment limit required in subsection (2) of this section, the new market insurer shall be deemed to have met its GAP enrollment limit requirement until the end of the new market period.

(4) If the insurer does not meet the GAP enrollment limit required in subsection (2) of this section in the subsequent quarter, the insurer shall use its quarterly enrollment at the time to project a new GAP enrollment limit in accordance with subsection (2) of this section.

(5) When the new market period has elapsed, the insurer shall be subject to the GAP enrollment limit of one-half (1/2) of one (1) percent of its total enrollment in the individual market as of the preceding December 31.

(6) A mandatory GAP participating insurer shall not have a limit on the number of individual GAP health benefit plans.

Section 4. Issuance of a GAP Health Benefit Plan. A GAP participating insurer shall, within two (2) months from the effective date of the insurer's GAP participation implementation date, identify an individual for GAP health benefit plan coverage in accordance with KRS 304.17A-430(1)(b).

Section 5. AUM Criteria. (1) A GAP participating insurer electing to use AUM shall submit to the commissioner for review and approval written documentation of its underwriting guideline criteria for AUM.

(2) If underwriting documentation does not exist, other documentation which supports underwriting AUM may be submitted to the commissioner for review and approval.

(3) After approval of an insurer's underwriting guideline criteria for AUM, the insurer shall resubmit its underwriting guideline criteria for AUM by December 1 of each year for approval for the subsequent year.

(4) Any change to the underwriting guideline criteria for AUM submitted for a subsequent calendar year shall require:

(a) Justification for the change; and

(b) Documentation of the insurer's underwriting criteria.

(5) Upon receipt of approval by the commissioner, a GAP participating insurer shall implement its underwriting guideline criteria for AUM.

(6) A GAP participating insurer shall use the same standards for AUM as for other high-cost conditions as established in KRS 304.17A-430(1) and (2).

(7) If an individual was issued a policy by an insurer in the individual market between July 15, 1995, and July 1, 1998, to be reimbursed from the GAP fund, the insurer shall demonstrate that the insured, at the time of issuance of the policy:

(a) Was diagnosed with a condition on the list of high-cost conditions; or

(b) Met the insurer's approved AUM requirements and the insured would not have met the insurer's most recent underwriting guidelines in existence prior to July 15, 1995.

(8) If an individual was issued a policy by an insurer in the individual market after July 1, 1998, to be reimbursed from the GAP fund the insurer shall demonstrate that the insured at the time of issuance of the policy:

(a) Was diagnosed with a condition on the list of high-cost conditions; or

(b) Met the insurer's approved AUM requirements.

Section 6. GAP Participation Termination Requirements. (1) A mandatory GAP participating insurer shall not terminate its participation in GAP.

(2) A voluntary GAP participating insurer may elect to terminate its status as a GAP participating insurer.

(3) A voluntary GAP participating insurer that elects to terminate its status as a GAP participating insurer shall do so by submitting a termination letter to the commissioner by September 1 of each year that shall include:

(a) The effective date of termination for issuing a GAP health benefit plan; and

(b) The reason for the termination from GAP.

(4) Upon notification of termination to the commissioner, the voluntary GAP participating insurer shall:

(a) Be prohibited from issuing a new GAP health benefit plan;

(b) Provide a ninety (90) day notice to GAP participants advising the participants of the insurer's GAP participation termination status; and

(c) Provide coverage to currently enrolled GAP participants until renewal of the GAP health benefit plan.

(5) A voluntary GAP participating insurer failing to notify the commissioner by September 1 of each year of its GAP termination status as established in subsection (2) of this section shall issue and renew GAP health benefit plans for the subsequent calendar year.

(6) A voluntary GAP participating insurer terminating its GAP participation may subsequently reapply to become a GAP participating insurer subject to approval by the commissioner.

(7) The commissioner may elect to terminate the status of a GAP participating insurer that is in hazardous financial condition pursuant to 806 KAR 3:150. (25 Ky.R. 1286; Am. 2156; eff. 3-19-99; TAm eff. 8-9-2007; Crt eff. 2-26-2020; TAm eff. 3-10-2020.)