AN ACT relating to reorganization.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 3 of this Act:

(1) "Board" means the Kynect Advisory Board created in Section 3 of this Act;

(2) "Cabinet" means the Cabinet for Health and Family Services;

(3) "Exchange" means the Kentucky Health Benefit and Health Information Exchange;

(4) "Office" means the Office of the Kentucky Health Benefit and Health Information Exchange established in Section 2 of this Act; and

(5) "Secretary" means the secretary of the Cabinet for Health and Family Services.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

(1) The Office of the Kentucky Health Benefit and Health Information Exchange is established within the Cabinet for Health and Family Services. The office shall administer the provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

(2) The office shall be headed by an executive director appointed by the secretary with the approval of the Governor in accordance with KRS 12.050. The executive director shall exercise authority over the office, and the office shall be composed of such organizational entities as deemed appropriate by the secretary.

(3) The office shall:

(a) Facilitate enrollment in health coverage and the purchase and sale of qualified health plans in the individual market;

(b) Take actions as necessary to enable eligible individuals to receive premium tax credits and cost-sharing reductions and to enable eligible small

businesses to receive tax credits, in compliance with all applicable federal and state laws and regulations;

(c) At a minimum, carry out the functions and responsibilities required under Section 1311 of the Patient Protection and Affordable Care Act, to implement and comply with federal regulations issued under Section 1321(a) of the Patient Protection and Affordable Act; and

(d) Regularly consult with stakeholders in accordance with 45 C.F.R. sec. 155.130.

(4) The office may enter into contracts and other agreements with appropriate entities, including but not limited to federal, state, and local agencies, as permitted under 45 C.F.R. sec. 155.110, to the extent necessary to carry out the duties and responsibilities of the office, provided that such agreements incorporate adequate protections with respect to the confidentiality of any information to be shared.

(5) The office shall review and discuss issues with the Kynect Advisory Board as established in Section 3 of this Act.

(6) The office shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section.

(7) The office shall not establish procedures and rules that conflict with or prevent the application of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 194A IS CREATED TO READ AS FOLLOWS:

(1) The Kynect Advisory Board is created and shall be attached to the Cabinet for Health and Family Services for administrative and technical support purposes.

(2) The members of the board shall be appointed by the Governor and shall have relevant experience in health benefits administration, health care finance, health

plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(3) The board shall include:

(a) The secretary of the Cabinet for Health and Family Services or his or her designee;

(b) The commissioner of the Department for Medicaid Services or his or her designee;

(c) The commissioner of the Department of Insurance or his or her designee;

(d) The commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities or his or her designee;

(e) Three (3) representatives of insurers with a health line of authority and that offer health benefit plans in Kentucky;

(f) One (1) representative of insurance agents licensed to sell health insurance in Kentucky;

(g) Three (3) representatives of nonfacility-based health care providers licensed in Kentucky;

(h) Four (4) representatives of facility-based health care providers licensed in Kentucky;

(i) One (1) representative of small employers doing business in Kentucky;

(j) One (1) representative of an individual purchaser of health benefit plans in Kentucky; and

(k) Four (4) consumer representatives.

(4) All members other than those who serve by virtue of their positions shall be selected by the Governor from a list of names submitted by any interested parties. The Governor may request the submission of additional names.

(5) Members serving under subsection (3)(a) to (d) of this section shall serve by

virtue of their positions. Members serving under subsection (3)(e) to (j) of this section shall be appointed for a term of two (2) or three (3) years as designated by the Governor.

(6) The Governor shall appoint the chair from the members of the board.

(7) The board may establish subcommittees consisting of consumers and other stakeholder groups or interested parties to study specific policy issues and advise the board.

➔Section 4. KRS 304.17B-001 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

As used in ***Sections 4 to 14 of this Act***~~[this subtitle]~~, unless the context requires otherwise:

(1) "Administrator" ***has the same meaning as***~~[is defined]~~ in KRS 304.9-051(1);

(2) "Agent" ***has the same meaning as***~~[is defined]~~ in KRS 304.9-020;

(3) "Assessment process" means the process of assessing and allocating guaranteed acceptance program losses or Kentucky Access funding as provided for in ***Section 9 of this Act***~~[KRS 304.17B-021]~~;

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

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

(6) "Commissioner" ***means the commissioner of the Department of Insurance***~~[is defined in KRS 304.1-050(1)]~~;

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

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

(8)~~[(9)]~~ "Enrollee" means a person who is enrolled in a health benefit plan offered

under Kentucky Access;

(9) ~~[(10)]~~ "Eligible individual" ***has the same meaning as*** ~~[is defined]~~ in KRS 304.17A-005(11);

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

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

(12) ~~[(13)]~~ "Health benefit plan" is defined in KRS 304.17A-005(22);

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

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

(14) ~~[(16)]~~ "Insurer" ***has the same meaning as*** ~~[is defined]~~ in KRS 304.17A-005(27);

(15) ~~[(17)]~~ "Kentucky Access" means the program established in accordance with ***Sections 4 to 14 of this Act*** ~~[KRS 304.17B-001 to 304.17B-031]~~;

(16) ~~[(18)]~~ "Kentucky Access Fund" means the fund established in ***Section 9 of this Act*** ~~[KRS 304.17B-021]~~;

(17)~~[(19)]~~ "Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in ***subsection (5) of Section 5 of this Act***~~[KRS 304.17B-003(5)]~~;

(18)~~[(20)]~~ "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco Master Settlement ***Agreement*** moneys for program initiatives listed in ***subsection (5) of Section 5 of this Act***~~[KRS 304.17B-003(5)]~~;

(19)~~[(21)]~~ "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

(20) "Office" means the Office of the Kentucky Health Benefit and Health Information Exchange in Section 2 of this Act;

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

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

~~(24) "Pre-existing condition exclusion" is defined in KRS 304.17A-220(6);]~~

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

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

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

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

➔Section 5. KRS 304.17B-003 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) There is hereby established the Kentucky Health Care Improvement Authority as an agency, instrumentality, and political subdivision of the Commonwealth and a public body corporate and politic with all the powers, duties, and responsibilities

conferred upon it by statute and necessary or convenient to carry out its functions. The authority shall be administered by a board of fifteen (15) members and is created to perform the public functions of administering programs financed by the funds appropriated to the authority in conformance with ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~ and any terms and conditions established by the General Assembly as a part of the act appropriating the funds. The members of the board shall consist of the following:

(a) The ***secretary of the Cabinet for Health and Family Services, or the secretary's***~~[commissioner of the Department of Insurance, or the commissioner's]~~ designated representative, who shall serve as chair;

(b) The ***commissioner of the Department of Insurance, or the commissioner's***~~[secretary of the Cabinet for Health and Family Services, or the secretary's]~~ designated representative, who shall serve as vice chair;

(c) Two (2) nonvoting members serving ex officio from the House of Representatives, one (1) of whom shall be appointed by the Speaker of the House and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(d) Two (2) nonvoting members serving ex officio from the Senate, one (1) of whom shall be appointed by the President of the Senate and one (1) appointed by the minority floor leader, and who shall serve a term of two (2) years;

(e) The deans of the University of Louisville School of Medicine and the University of Kentucky College of Medicine, or their designated representatives;

(f) The commissioner of the Department for Public Health, or the commissioner's designated representative;

(g) Two (2) representatives of Kentucky health care providers, who shall be appointed by the Governor; and

(h) Four (4) citizens at large of the Commonwealth, who shall be appointed by the Governor.

(2) The terms of office of the initial appointments of the citizen at-large members of the board shall expire one (1), two (2), three (3), and four (4) years respectively from the expiration date of the initial appointment. One (1) of the initial terms of the representatives of health care providers, at least one (1) of whom shall be male and at least one (1) of whom shall be female, shall be for two (2) years and one (1) shall be for four (4) years. All succeeding appointments shall be for four (4) years from the expiration date of the term of the initial appointment. Two (2) of the citizens at large shall be male and two (2) shall be female. Board members shall serve until their successors are appointed.

(3) In making private sector and citizen-at-large appointments to the board, the Governor shall ***ensure***~~[assure]~~ broad geographical and ethnic representation as well as representation from consumers and the major sectors of Kentucky's health care and health insurance businesses. Private sector and citizen-at-large members shall serve without compensation but shall be reimbursed for reasonable and necessary expenses.

(4) The authority shall establish procedures for accountability, including the review of expenditures, and develop mechanisms to measure the success of programs that receive allocated funds in accordance with any criteria or instructions provided by the General Assembly. The authority shall be attached to the Department of Insurance for administrative purposes and shall establish advisory boards it deems appropriate, which shall consist of health insurance consumers, health care providers, and insurance company representatives, to assist with oversight of fund expenditures.

(5) Grants and funds obtained under ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~ shall be used for expenditures as follows:

(a) Seventy percent (70%) of all moneys in the fund shall be placed into the Kentucky Access fund for the purpose of funding Kentucky Access;

(b) Twenty percent (20%) of all moneys in the fund shall be spent on a collaborative partnership between the University of Louisville and the University of Kentucky dedicated to lung cancer research; and

(c) Ten percent (10%) of all moneys in the fund shall be used to discourage the use of harmful substances by minors.

(6) The authority shall ***ensure***~~[assure]~~ that a public hearing is held on the expenditure of funds allocated under this section, except for funds allocated to the Kentucky Access fund. Advertisement of the public hearing shall be published at least once but may be published two (2) more times, if one (1) publication occurs not less than seven (7) days nor more than twenty-one (21) days before the scheduled date of the public hearing. The authority shall submit an annual report to the Governor and the General Assembly indicating how the funds were used and an evaluation of the program's effectiveness in health care and access to health insurance for Kentucky residents.

(7) Neither the authority nor its employees shall be liable for any obligations of any of the programs established under ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~. No member or employee of the authority shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~, unless the act or omission constitutes willful or wanton misconduct. The authority may provide in its policies and procedures for indemnification of, and legal representation for, its members and employees.

(8) The authority shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of ***Sections 4 to 14 of this Act***~~[KRS~~

~~304.17B-001 to 304.17B-031]~~, including, but not limited to, retaining the staff it deems necessary for the proper performance of its duties.

(9) The authority shall meet at least quarterly and at other times upon call of the chair or a majority of the authority.

➔Section 6. KRS 304.17B-005 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) There is hereby created Kentucky Access, which shall ensure that health coverage is made available to each Kentucky individual resident applying and qualifying for coverage. Any health coverage provided under this section shall ***end no later than December 31, 2013***~~[begin no sooner than January 1, 2001]~~. Kentucky Access is designed for the purpose of implementing an acceptable alternative mechanism within the meaning of 42 U.S.C. sec. 300gg-44(a)(1) so that Kentucky may preserve the flexibility over the regulation of health coverage allowed by federal law.

(2) Kentucky Access shall operate under the ***Office of the Kentucky Health Benefit and Health Information Exchange***~~[Division of Kentucky Access in the Department of Insurance. The division shall be headed by a division director appointed by the secretary of the Public Protection Cabinet in accordance with KRS 12.050]~~.

(3) Neither the ***Cabinet for Health and Family Services***~~[department]~~ nor its employees shall be liable for any obligations of Kentucky Access. No member or employee of the ***cabinet***~~[department]~~ shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~, unless such act or omission constitutes willful or wanton misconduct. The ***cabinet***~~[department]~~ may provide in its policies and procedures for indemnification of, and legal representation for, its members and employees.

➔Section 7. KRS 304.17B-007 is repealed, reenacted as a new section of KRS

Chapter 194A, and amended to read as follows:

In its duties to operate and administer Kentucky Access, the ***office*** ~~[department]~~ shall, through itself or designated agents:

(1) Establish administrative and accounting procedures for the operation of Kentucky Access;

(2) Enter into contracts as necessary;

(3) Take legal action necessary:

(a) To avoid the payment of improper claims against Kentucky Access or the coverage provided by or through Kentucky Access;

(b) To recover any amounts erroneously or improperly paid by Kentucky Access;

(c) To recover any amounts paid by the Kentucky Access as a result of mistake of fact or law;

(d) To recover other amounts due Kentucky Access; or

(e) To operate and administer its obligations under ***Sections 4 to 14 of this Act*** ~~[the provisions of KRS 304.17B-001 to 304.17B-031]~~;

(4) ~~[Establish, and modify as appropriate, rates, rate schedules, rate adjustments, premium rates, expense allowances, claim reserve formulas, and any other actuarial function appropriate to the administration and operation of Kentucky Access. Premium rates and rate schedules may be adjusted for appropriate factors, including, but not limited to, age and sex, and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;~~

~~(5)]~~ Establish procedures under which applicants and participants in Kentucky Access shall have an internal grievance process and a mechanism for external review through an independent review organization in accordance with this chapter;

~~[(6) Select a third-party administrator in accordance with KRS 304.17B-011;~~

~~(7) Require that all health benefit plans, riders, endorsements, or other forms and~~

~~documents used to administer Kentucky Access meet the requirements of Subtitles 12, 14, 17, 17A, and 38 of this chapter;~~

~~(8) Adopt nationally recognized uniform claim forms in accordance with this chapter;~~

~~(9) Develop and implement a marketing strategy to publicize the existence of Kentucky Access, including, but not limited to, eligibility requirements, procedures for enrollment, premium rates, and a toll-free telephone number to call for questions;~~]

(5)[~~(10)~~] Establish and review annually provider reimbursement rates that ensure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under Kentucky Access at least to the extent that such care and services are available to the general population. The ***office***[~~department~~] shall only authorize contracts with health care providers that prohibit the provider from collecting from the enrollee any amounts in excess of copayment amounts, coinsurance amounts, deductible amounts, and amounts for noncovered services;

(6)[~~(11)~~] Conduct periodic audits to ***ensure***[~~assure~~] the general accuracy of the financial and claims data submitted to the ***office***[~~department~~] and be subject to an annual audit of its operations;

(7)[~~(12) Issue health benefit plans January 1, 2001, or thereafter, in accordance with the requirements of KRS 304.17B-001 to 304.17B-031;~~

~~(13) Require a referral fee of fifty dollars ($50) to be paid to agents who refer applicants who are subsequently enrolled in Kentucky Access. The referral fee shall be paid only on the initial enrollment of an applicant. Referral fees shall not be paid on any enrollments of enrollees who have been previously enrolled in Kentucky Access, or for renewals for enrollees;~~

~~(14)~~] Bill and collect premiums from enrollees in the amount determined by the ***office***[~~department~~];

(8)[~~(15)~~] Assess insurers and stop-loss carriers in accordance with ***Section 9 of this***

Act~~[KRS 304.17B-021]~~;

(9)~~[(16)]~~ Reimburse GAP participating insurers for GAP losses pursuant to ***Section 9 of this Act***~~[KRS 304.17B-021]~~;

(10)~~[(17) Establish a provider network for Kentucky Access by developing a statewide provider network or by contracting with an insurer for a statewide provider network. In the event the department contracts with an insurer, the department may take into consideration factors including, but not limited to, the size of the provider network, the composition of the provider network, and the current market rate of the provider network. The provider network shall be made available to the third-party administrator specified in KRS 304.17B-011 and shall be limited to Kentucky Access enrollees.~~

~~(18)]~~ Be audited by the Auditor of Public Accounts; ***and***

(11)~~[(19) By administrative regulation, amend the definition of high-cost conditions provided in KRS 304.17B-001 by adding other high-cost conditions;~~

~~(20) The department shall report on an annual basis to the Interim Joint Committee on Banking and Insurance the separation plan pursuant to KRS 304.17A-080 for the division of duties and responsibilities between the operation of the Department of Insurance and the operation of Kentucky Access; and~~

~~(21)]~~ Any other actions as may be necessary and proper for the execution of the ~~[department's]~~powers, duties, and obligations ***of the office under Sections 4 to 14 of this Act***~~[under KRS 304.17B-001 to 304.17B-031]~~.

➔Section 8. KRS 304.17B-009 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

In its duties to operate and administer Kentucky Access, the ***office***~~[department]~~ may, through itself or third parties:

(1) Exercise any and all powers granted to insurers under ***KRS Chapter 304***~~[this chapter]~~; and

(2) Sue or be sued.

➔Section 9. KRS 304.17B-021 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) ***The office***~~[In addition to the other powers enumerated in KRS 304.17B-001 to 304.17B-031, the department]~~ shall assess insurers in the amounts specified in this section. The assessment shall be used for the purpose of funding GAP losses and Kentucky Access.

(a) The amount of the assessment for each calendar year shall be as follows:

1. From each stop-loss carrier, an amount that is equal to two dollars ($2) upon each one hundred dollars ($100) of health insurance stop-loss premiums;

2. From all insurers, an amount based on the total amount of all health benefit plan premiums earned during the prior assessment period and paid by all insurers who received any of the health benefit plan premiums on which the annual assessment is based. The percentage rate used for the annual assessment shall be the same percentage rate as calculated in the GAP risk adjustment process for the six (6) month period of July 1, 1998, through December 31, 1998;

3. If determined necessary by the ***office***~~[department]~~, a second assessment may be assessed in the same manner as the annual assessment in subparagraph 2. of this paragraph; and

4. In no event shall the sum of the first assessment provided for in subparagraph 2. of this paragraph and the second assessment provided for in subparagraph 3. of this paragraph be greater than one percent (1%) of the total amount of all assessable health benefit plan premiums earned during the prior assessment period.

(b) The first assessment shall be for the period from January 1, 2000, through

December 31, 2000, and shall be paid on or before March 31, 2001. Subsequent annual assessments shall be paid on or before March 31 of the year following the assessment period.

(2) Every supporting insurer shall report to the ***office*** ~~[department]~~, in a form and at the time as the ***office*** ~~[department]~~ may specify, the following information for the specified period:

(a) The insurer's total stop-loss premiums and health benefit plan premiums in the individual, small group, large group, and association markets; and

(b) Other information as the ***office*** ~~[department]~~ may require.

(3) As part of the assessment process, the ***office*** ~~[department]~~ shall establish and maintain the Kentucky Access fund. All funds shall be held at interest, in a single depository designated in accordance with KRS 304.8-090(1) under a written trust agreement in accordance with KRS 304.8-095. All expense and revenue transactions of the fund shall be posted to the Management Administrative Reporting System (MARS) and its successors.

(4) The Kentucky Access fund shall be funded from the following sources:

(a) Premiums paid by Kentucky Access enrollees;

(b) The funds designated for Kentucky Access in the Kentucky Health Care Improvement fund;

(c) Appropriations from the General Assembly;

(d) All premium taxes collected under KRS Chapter 136 from any insurer, and any retaliatory taxes collected under KRS 304.3-270 from any insurer, for accident and health premiums that are in excess of the amount of the premium taxes and retaliatory taxes collected for the calendar year 1997;

(e) Annual assessments from supporting insurers;

(f) A second assessment from supporting insurers;

(g) Gifts, grants, or other voluntary contributions;

(h) Interest or other earnings on the investment of the moneys held in the account; and

(i) Any funds remaining on January 1, ***2014*** ~~[2001]~~, in the guaranteed acceptance program account may be transferred to the Kentucky Access fund.

(5) The ***office*** ~~[department]~~ shall determine on behalf of Kentucky Access the premiums, the expenses for administration, the incurred losses, taking into account investment income and other amounts needed to satisfy reserves, estimated claim liabilities, and other obligations for each calendar year. The ***office*** ~~[department]~~ shall also determine the amount of the actual guaranteed acceptance program plan losses for each calendar year. The ***office*** ~~[department]~~ shall assess insurers as follows:

(a) On or before March 31 of each year, the amount set forth in subsection (1)(a)1. and (1)(a)2. of this section.

(b) If the amount of actual guaranteed acceptance program plan losses exceeds the assessment provided for in paragraph (a) of this subsection, a second assessment shall be authorized under subsection (1)(a)3. of this section. If the amount of GAP losses exceeds the assessments provided under subsection (1)(a)1., subsection (1)(a)2., and subsection (1)(a)3. of this section, moneys received and available from the Kentucky Health Care Improvement Fund after the ***office*** ~~[department]~~ determines available funding for Kentucky Access for the current calendar year pursuant to subsection (6) of this section, shall be used to reimburse GAP participating insurers for any actual guaranteed acceptance program losses. If the amount of GAP losses exceeds the amount in the Kentucky Health Care Improvement Fund after reserving sufficient funds for Kentucky Access for the current year, each GAP participating insurer shall be reimbursed up to the amount of its proportional share of actual guaranteed acceptance program plan losses from the fund. Effective for any assessment on or after January 1, 2001, in calculating GAP losses, total

premiums and total claims of the GAP participating insurer shall be used. Actual guaranteed acceptance program losses shall be calculated as the difference between the total GAP claims and the total GAP premiums on an aggregate basis.

(c) If GAP losses are fully covered by the assessment process provided for in subsection (1)(a)1. and (1)(a)2. of this section and the second assessment provided for in subsection (1)(a)3. of this section is not necessary to cover GAP losses, and as determined by the ***office*** ~~[department]~~ using reasonable actuarial principles Kentucky Access funding is needed, a second assessment provided for in subsection (1)(a)3. of this section shall be completed.

(6) After the end of each calendar year, GAP losses shall be reimbursed only after the ***office*** ~~[department]~~ determines that appropriate funding is available for Kentucky Access for the current calendar year. GAP losses shall be reimbursed after reserving sufficient funds for Kentucky Access.

(7) With respect to a GAP participating insurer who reasonably will be expected both to pay assessments and to receive payments from the assessment fund, the ***office*** ~~[department]~~ shall calculate the net amount owed to or to be received from the fund, and the ***office*** ~~[department]~~ shall only collect assessments for or make payments from the fund based upon net amounts.

(8) Insurers paying an assessment may include in any health insurance rate filing the amount of these assessments as provided for in Subtitle 17A of ***KRS Chapter 304*** ~~[this chapter]~~.

(9) Insurers shall pay any assessment amounts authorized in ***Sections 4 to 14 of this Act*** ~~[KRS 304.17B-001 to 304.17B-031]~~ within thirty (30) days of receiving notice from the ***office*** ~~[department]~~ of the assessment amount.

(10) Any surpluses remaining in the Kentucky Access fund after completion of the assessment process for a calendar year shall be maintained for use in the assessment

process for future calendar years and such funds shall not lapse. The general fund appropriations to the Kentucky Access fund shall not lapse.

(11) Assessments on health benefit plan premiums that are required under ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~ shall not be applied to premiums received by an insurer for state employees, Medicaid recipients, Medicare beneficiaries, and CHAMPUS insureds.

(12) The ***office***~~[department]~~ shall direct that receipts of Kentucky Access be held at interest, and may be used to offset future losses or to reduce plan premiums in accordance with the terms of ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~. As used in this subsection, "future losses" may include reserves for incurred but not reported claims.

(13) The ***office***~~[department]~~ shall conduct examinations of insurers and stop-loss carriers reasonably necessary to determine if the information provided by the insurers or stop-loss carriers is accurate.

(14) The insurer, as a condition of conducting health insurance business in Kentucky, shall pay the assessments specified in ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~.

(15) The stop-loss carrier, as a condition of doing health insurance business in Kentucky, shall pay the assessments specified in ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~.

➔Section 10. KRS 304.17B-023 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) After the end of each calendar year, a GAP participating insurer shall report the following information for the previous calendar year:

(a) The total earned premium in the individual, small group, large group, and association markets;

(b) The number of GAP policies in force as of December 31;

(c) The amount of the insurer's GAP premiums received during the calendar year covered by the report;

(d) The amount of the insurer's GAP claims paid during the calendar year covered by the report;

(e) The amount of the insurer's GAP losses; and

(f) Other information as the ***office*** ~~[department]~~ may require to be reported.

(2) After the end of each calendar year, and based upon the reports filed under subsection (1) of this section, the ***office*** ~~[department]~~ shall calculate and provide to each insurer who filed a report the following information relating to the calendar year:

(a) The amount of each reporting insurer's market share;

(b) The total amount of GAP premiums for all reporting insurers;

(c) The total amount of GAP claims paid by all reporting insurers;

(d) The amount of total actual GAP losses;

(e) The amount of the insurer's assessment or refund; and

(f) Other information as the ***office*** ~~[department]~~ may elect to calculate and report.

The ***office*** ~~[department]~~ shall complete its calculation and provide each insurer the results of its calculation within sixty (60) days after receiving all required information.

(3) The ***office*** ~~[department]~~ shall pay GAP losses to GAP participating insurers in accordance with this section and ***Section 9 of this Act*** ~~[KRS 304.17B-021(5)]~~.

(4) The ***office*** ~~[department]~~ shall conduct examinations of insurers participating in Kentucky Access as are reasonably necessary to determine if the information provided by the insurers is accurate.

➔Section 11. KRS 304.17B-025 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

~~[(1) Any health benefit plan issued to a GAP qualified individual under the GAP~~

~~program shall be renewed at the option of the enrollee, except for the reasons set out in KRS 304.17A-240.~~

~~(2) ~~]The Guaranteed Acceptance Program shall remain in effect except for KRS 304.17A-400, 304.17A-420, 304.17A-440, 304.17A-460, 304.17A-470, and 304.17A-480.

➔Section 12. KRS 304.17B-027 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

Kentucky Access and the ***office***~~[department]~~ shall be exempt from all taxes levied by the state or any of its subdivisions.

➔Section 13. KRS 304.17B-029 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) Sixty (60) days prior to the regular session of the General Assembly ***that is held*** in the year ***2016***~~[2002]~~, and sixty (60) days prior to each subsequent regular session of the General Assembly thereafter, the ***office***~~[department]~~ shall submit a written report to the Legislative Research Commission and provide a detailed briefing. The report shall contain an evaluation of Kentucky Access, an evaluation of issues concerning high-risk individuals, and other information as the ***office***~~[department]~~ deems necessary.

(2) Beginning no later than June 30, ***2015***~~[2001]~~, and annually thereafter, the Auditor of Public Accounts shall audit Kentucky Access and within sixty (60) days of completion of the audit shall submit a copy of the audit to the Legislative Research Commission and the Department of Insurance.

➔Section 14. KRS 304.17B-031 is repealed, reenacted as a new section of KRS Chapter 194A, and amended to read as follows:

(1) The ***office***~~[department]~~ shall promulgate administrative regulations necessary to carry out the provisions of ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~.

(2) Kentucky Access shall be subject to ***Sections 4 to 14 of this Act***~~[the provisions of this subtitle]~~, and to the following provisions of ***KRS Chapter 304***~~[this chapter]~~, to the extent applicable and not in conflict with the expressed provisions of ***Sections 4 to 14 of this Act***~~[this subtitle]~~:

(a) Subtitle 1;

(b) Subtitle 2;

(c) Subtitle 3;

(d) Subtitle 5;

(e) Subtitle 8;

(f) Subtitle 9;

(g) Subtitle 12;

(h) Subtitle 14;

(i) Subtitle 17;

(j) Subtitle 17A;

(k) Subtitle 25;

(l) Subtitle 38; and

(m) Subtitle 47.

➔Section 15. KRS 91A.080 is amended to read as follows:

(1) The legislative body of each local government which elects to impose and collect license fees or taxes upon insurance companies for the privilege of engaging in the business of insurance may, except as provided in subsection (10) of this section, enact or change its license fee or rate of tax to be effective July 1 of each year on a prospective basis only and shall file with the commissioner of insurance at least one hundred (100) days prior to the effective date, a copy of all ordinances and amendments which impose a license fee or tax. No less than eighty-five (85) days prior to the effective date, the commissioner of insurance shall promptly notify each insurance company engaged in the business of insurance in the Commonwealth of

those local governments which have elected to impose the license fees or taxes and the current amount of the license fee or rate of tax.

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

(3) Any license fee or tax imposed by a local government upon any insurance company with respect to any policy which is not a life insurance policy shall be based upon the premiums actually collected by the insurance company within each calendar quarter on risks located within the corporate limits of the local government on those classes of business which the insurance company is authorized to transact, less all premiums returned to policyholders. In determining the amount of license fee or tax to be collected and to be paid to the local government, the insurance company shall use the tax rate effective on the first day of the policy term. When an insurance company collects a premium as a result of a change in the policy during the policy term, the tax rate used shall be the rate in effect on the effective date of the policy change. With respect to premiums returned to policyholders, the license fee or tax shall be returned by the insurance company to the policyholder pro rata on the unexpired amount of the premium at the same rate at which it was collected and shall be taken as a credit by the insurance company on its next quarterly report to the local government.

(4) The Department of Insurance shall, by administrative regulation, provide for a reasonable collection fee to be retained by the insurance company or its agent as compensation for collecting the tax, except that the collection fee shall not be more than fifteen percent (15%) of the fee or tax collected and remitted to the local government or two percent (2%) of the premiums subject to the tax, whichever is

less. To facilitate computation, collection, and remittance of the fee or tax and collection fee provided in this section, the fees or taxes set out in subsection (1), (2), or (3) of this section, together with the collection fee in this section, may be rounded off to the nearest dollar amount.

(5) Pursuant to KRS 304.3-270, if any other state retaliates against any Kentucky domiciliary insurer because of the requirements of this section, the commissioner of insurance shall impose an equal tax upon the premiums written in this state by insurers domiciled in the other state.

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

(7) (a) Upon written request of the legislative body of any local government, at the expense of the requesting local government, which shall be paid in advance by the local government to the Department of Insurance, the Department of Insurance shall audit, or cause to be audited by contract with qualified auditors, the books or records of the insurance companies or agents subject to the fee or tax to determine whether the fee or tax is being properly collected and remitted, and the findings of the audit shall be reported to the local government and the insurance company subject to the audit. An insurance company may appeal the findings of the audit conducted under this subsection and any assessment issued pursuant to the audit findings in accordance with the provisions of KRS 91A.0804(5).

(b) Willful failure to properly collect and remit the fee or tax imposed by a local government pursuant to the authority granted by this section shall constitute grounds for the revocation of the license issued to an insurance company or agent under the provisions of KRS Chapter 304.

(c) If the Department of Insurance finds that an insurance company has willfully

engaged in a pattern of business conduct that fails to properly collect and remit the fee or tax imposed by a local government pursuant to the authority granted by this section, the Department of Insurance may assess the responsible insurance company an appropriate penalty fee no greater than ten percent (10%) of the additional license fees or taxes determined to be owed to the local government. The penalty fee shall be paid to the local government owed the license fee or tax less any administrative costs of the Department of Insurance in enforcing this section. Any insurance company or agent held responsible for a penalty fee may request a hearing with the Department of Insurance to be conducted pursuant to KRS 304.2-310 to 304.2-370 regarding the finding of a willful violation and the subsequent penalty fee.

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

(a) Casualty;

(b) Automobile;

(c) Inland marine;

(d) Fire and allied perils;

(e) Health; and

(f) Life.

(9) Any license fee or tax not paid on or before the due date shall bear interest at the tax interest rate as defined in KRS 131.010(6) from the date due until paid. Such interest payable to the local government is separate of penalties provided for in subsection (7) of this section. In addition, the local government may assess a ten percent (10%) penalty for a tax or fee not paid within thirty (30) days after the due

date.

(10) No license fee or tax imposed under this section shall apply to premiums:

(a) Received on policies of group health insurance provided for state employees under KRS 18A.225;

(b) Received on policies insuring employers against liability for personal injuries to their employees or the death of their employees caused thereby, under the provisions of KRS Chapter 342;

(c) Received on health insurance policies issued to individuals;

(d) Received on policies issued through Kentucky Access created in ***Sections 4 to 14 of this Act*** ~~[Subtitle 17B of KRS Chapter 304]~~;

(e) Received on policies for high deductible health plans as defined in 26 U.S.C. sec. 223(c)(2);

(f) Received on multistate surplus lines, defined as non-admitted insurance as provided in Title V, Subtitle B, the Non-Admitted and Reinsurance Reform Act of 2010, of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203;

(g) Paid to insurance companies or surplus lines brokers by nonprofit self-insurance groups or self-insurance entities whose membership consists of school districts; or

(h) Paid to insurance companies or surplus lines brokers by nonprofit self-insurance groups or self-insurance entities whose membership consists of cities, counties, charter county governments, urban-county governments, consolidated local governments, unified local governments, school districts, or any other political subdivisions of the Commonwealth.

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

(12) Insurance companies which pay license fees or taxes pursuant to this section shall

credit city license fees or taxes against the same license fees or taxes levied by the county, when the license fees or taxes are levied by the county on or after July 13, 1990. For purposes of this subsection, a consolidated local government, urban-county government, charter county government, or unified local government shall be considered a county.

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

(14) A county may impose a license fee or tax covering the entire county or may limit the application of the fee or tax to the unincorporated portions of the county.

➔Section 16. KRS 164.476 is amended to read as follows:

(1) The "Lung Cancer Research Fund" is created and shall receive funds each year from the Kentucky health care improvement fund in the amount specified in ***subsection*** ~~[KRS 304.17B-003]~~ (5)(b) ***of Section 5 of this Act***. The lung cancer research fund shall be used to finance the Lung Cancer Research Project described in subsection (5) of this section. No revenues from the lung cancer research fund shall be allocated until the board has adopted the strategic plan described in subsections (5) and (6) of this section.

(2) A research consortium between the University of Kentucky and the University of Louisville is created and shall be known as the Governance Board of the Lung Cancer Research Project. The consortium shall be attached to the Council on Postsecondary Education for administrative purposes.

(3) The board shall consist of nine (9) members appointed by the Governor as follows:

(a) Two (2) members shall be from the faculty of the School of Medicine at the University of Kentucky;

(b) Two (2) members shall be from the faculty of the School of Medicine at the University of Louisville;

(c) Two (2) members shall be from the Council on Postsecondary Education; and

(d) Three (3) members shall be from the state at large, one (1) of whom shall be appointed chair by the Governor.

(4) Except as provided in paragraphs (a) to (d) of this subsection, the terms of the members shall be for four (4) years and until their successors are appointed and confirmed. A vacancy on the board shall be filled for the remainder of the unexpired term in the same manner as the original appointment. Members may be reappointed. The initial appointments shall be for staggered terms, as follows:

(a) Two (2) members shall be appointed for one (1) year;

(b) Two (2) members shall be appointed for two (2) years;

(c) Two (2) members shall be appointed for three (3) years; and

(d) Three (3) members shall be appointed for four (4) years.

(5) The Governance Board of the Lung Cancer Research Project shall develop and oversee the implementation of a twenty (20) year strategic plan that utilizes the resources of both the University of Louisville and the University of Kentucky in establishing the Lung Cancer Research Project. The Lung Cancer Research Project shall be a joint program to:

(a) Develop an expertise in the area of lung cancer research with an immediate focus on early detection and epidemiology and with an ultimate goal of eradication of lung cancer;

(b) Establish a statewide clinical trial network to make university-based clinical trials available to the community physician in order to bring the most innovative cancer treatments to all Kentuckians in need of these treatments;

(c) Leverage the resources earmarked for the Lung Cancer Research Project toward the certification of the cancer program at the University of Kentucky and the University of Louisville by the National Cancer Institute as a cancer center; and

(d) Undertake other initiatives consistent with the strategic plan.

(6) The strategic plan shall identify both short-term and long-term goals and the appropriate oversights to measure progress toward achievement of those goals; it shall be updated every two (2) years.

(7) The Governance Board of the Lung Cancer Research Project shall submit an annual report to the Governor and the Legislative Research Commission by September 1 each year for the preceding fiscal year, outlining its activities and expenditures.

(8) The Auditor of Public Accounts, on an annual basis, shall conduct a thorough review of all expenditures from the lung cancer research fund and, if necessary in the opinion of the Auditor, the operations of the Lung Cancer Research Project and the lung cancer research fund.

➔Section 17. KRS 304.17A-080 is amended to read as follows:

(1) There is hereby created and established a Health Insurance Advisory Council whose duties shall be to review and discuss with the commissioner any issues which impact the provision of health insurance in the state. The advisory council shall consist of nine (9) members: the commissioner plus eight (8) persons appointed by the Governor with the advice of the commissioner to serve two (2) year terms. The commissioner shall serve as chair of the advisory council.

(2) The eight (8) persons appointed by the Governor with the advice of the commissioner shall be:

(a) Two (2) representatives of insurers currently offering health benefit plans in the state;

(b) Two (2) practicing health care providers;

(c) Two (2) representatives of purchasers of health benefit plans; and

(d) Two (2) representatives of agents.

(3) The council shall:

(a) Review and discuss the design of the standard health benefit plan;

(b) Review and discuss the rate-filing process for all health benefit plans;

(c) Review and discuss the administrative regulations concerning this subtitle to be promulgated by the department;

(d) Make recommendations on high-cost conditions~~[as provided in KRS 304.17B-033]~~;

(e) Advise the Department of Insurance concerning the Department of Insurance's separation plan for the division of duties and responsibilities between the operation of the Department of Insurance and the operation of Kentucky Access;

(f) Review and discuss issues that impact Kentucky Access; and

(g) Review and discuss other issues at the request of the commissioner.

(4) The advisory council shall be a budgetary unit of the department which shall pay all of the advisory council's necessary operating expenses and shall furnish all office space, personnel, equipment, supplies, and technical or administrative services required by the advisory council in the performance of the functions established in this section.

➔Section 18. KRS 304.17A-095 is amended to read as follows:

(1) (a) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to any market segment other than a large group shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers. The insurer shall also submit a copy of the filing to the Attorney General and shall comply with the provisions of this

section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the commissioner. The insurer shall submit a new filing to reflect any material change to the previously filed and approved rate filing. For all other changes, the insurer shall submit an amendment to a previously approved rate filing.

(b) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to a large group as defined in KRS 304.17A-005 shall file the rating methodology with the commissioner and shall submit a copy of the filing to the Attorney General.

(2) (a) A rate filing under this section may be used by the insurer on and after the date of filing with the commissioner prior to approval by the commissioner. A rate filing shall be approved or disapproved by the commissioner within sixty (60) days after the date of filing. Should sixty (60) days expire after the commissioner receives the filing before approval or disapproval of the filing, the filing shall be deemed approved.

(b) In the circumstances of a filing that has been deemed approved or has been disapproved under paragraph (a) of this subsection, the commissioner shall have the authority to order a retroactive reduction of rates to a reasonable rate if the commissioner subsequently determines that the filing contained misrepresentations or was based on fraudulent information, and if after applying the factors in subsection (3) of this section the commissioner determines that the rates were unreasonable. If the commissioner seeks to order a retroactive reduction of rates and more than one (1) year has passed since the date of the filing, the commissioner shall consider the reasonableness of the rate over the entire period during which the filing has been in effect.

(3) In approving or disapproving a filing under this section, the commissioner shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium or fee charged;

(b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;

(c) Previous premium rates or fees for the policies or contracts to which the filing applies;

(d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;

(e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory;

(f) The effect on the rates of any assessment made under ***Section 9 of this Act*** ~~[KRS 304.17B-021]~~; and

(g) Other factors as deemed relevant by the commissioner.

(4) The rates for each policyholder shall be guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.

(5) At any time the commissioner, after a public hearing for which at least thirty (30) days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and subscribers if the commissioner determines that the rates or fees previously approved are in violation of this chapter.

(6) Notwithstanding subsection (2) of this section, premium rates may be used upon filing with the department of a policy form not previously used if the filing is accompanied by the policy form filing and a minimum loss ratio guarantee. Insurers may use the filing procedure specified in this subsection only if the affected policy forms disclose the benefit of a minimum loss ratio guarantee. An insurer may not elect to use the filing procedure in this subsection for a policy form that does not contain the minimum loss ratio guarantee. If an insurer elects to use the filing

procedure in this subsection for a policy form or forms, the insurer shall not use a filing of premium rates that does not provide a minimum loss ratio guarantee for that policy form or forms.

(a) The minimum loss ratio shall be in writing and shall contain at least the following:

1. An actuarial memorandum specifying the expected loss ratio that complies with the standards as set forth in this subsection;
2. A statement certifying that all rates, fees, dues, and other charges are not excessive, inadequate, or unfairly discriminatory;
3. Detailed experience information concerning the policy forms;
4. A step-by-step description of the process used to develop the experience loss ratio, including demonstration with supporting data;
5. A guarantee of a specific lifetime minimum loss ratio, that shall be greater than or equal to the following, taking into consideration adjustments for duration as set forth in administrative regulations promulgated by the commissioner:
    a. Sixty-five percent (65%) for policies issued to individuals or for certificates issued to members of an association that does not offer coverage to small employers;
    b. Seventy percent (70%) for policies issued to small groups of two (2) to ten (10) employees or for certificates issued to members of an association that offers coverage to small employers; and
    c. Seventy-five percent (75%) for policies issued to small groups of eleven (11) to fifty (50) employees;
6. A guarantee that the actual Kentucky loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards

referred to in subparagraph 5. of this paragraph, adjusted for duration;

7. A guarantee that the actual Kentucky lifetime loss ratio shall meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph; and

8. If the annual earned premium volume in Kentucky under the particular policy form is less than two million five hundred thousand dollars ($2,500,000), the minimum loss ratio guarantee shall be based partially on the Kentucky earned premium and other credibility factors as specified by the commissioner.

(b) The actual Kentucky minimum loss ratio results for each year at issue shall be independently audited at the insurer's expense and the audit shall be filed with the commissioner not later than one hundred twenty (120) days after the end of the year at issue. The audit shall demonstrate the calculation of the actual Kentucky loss ratio in a manner prescribed as set forth in administrative regulations promulgated by the commissioner.

(c) The insurer shall refund premiums in the amount necessary to bring the actual loss ratio up to the guaranteed minimum loss ratio.

(d) A Kentucky policyholder affected by the guaranteed minimum loss ratio shall receive a portion of the premium refund relative to the premium paid by the policyholder. The refund shall be made to all Kentucky policyholders insured under the applicable policy form during the year at issue if the refund would equal ten dollars ($10) or more per policy. The refund shall include statutory interest from July 1 of the year at issue until the date of payment. Payment shall be made not later than one hundred eighty (180) days after the end of the year at issue.

(e) Premium refunds of less than ten dollars ($10) per insured shall be aggregated by the insurer and paid to the Kentucky State Treasury.

(f) None of the provisions of subsections (2) and (3) of this section shall apply if premium rates are filed with the department and accompanied by a minimum loss ratio guarantee that meets the requirements of this subsection. Such filings shall be deemed approved. Each insurer paying a risk assessment under ***Section 9 of this Act***~~[KRS 304.17B-021]~~ may include the amount of the assessment in establishing premium rates filed with the commissioner under this section. The insurer shall identify any assessment allocated.

(g) The policy form filing of an insurer using the filing procedure with a minimum loss ratio guarantee will disclose to the enrollee, member, or subscriber as prescribed by the commissioner an explanation of the lifetime loss ratio guarantee, and the actual loss ratio, and any adjustments for duration.

(h) The insurer who elects to use the filing procedure with a minimum loss ratio guarantee shall notify all policyholders of the refund calculation, the result of the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than ten dollars ($10).

(i) Notwithstanding the provisions of this subsection, an insurer may amend the policy forms used before March 31, 2005, or may amend the minimum loss ratio guarantee on policy forms filed with the department and used by the insurer prior to March 31, 2005, to provide for a minimum loss ratio guarantee allowed under this subsection for policies issued, delivered, or renewed on or after March 31, 2005.

(7) The commissioner may by administrative regulation prescribe any additional information related to rates, fees, dues, and other charges as they relate to the factors set out in subsection (3) of this section that he or she deems necessary and relevant to be included in the filings and the form of the filings required by this

section. When determining a loss ratio for the purposes of loss ratio guarantee, the insurer shall divide the total of the claims incurred, plus preferred provider organization expenses, case management and utilization review expenses, plus reinsurance premiums less reinsurance recoveries by the premiums earned less state and local premium taxes less other assessments. For purposes of determining the loss ratio for any loss ratio guarantee pursuant to this section, the commissioner may examine the insurer's expenses for preferred provider organization, case management, utilization review, and reinsurance used by the insurer in calculating the loss ratio guarantee for reasonableness. Only those expenses found to be reasonable by the commissioner may be used by the insurer for determining the loss ratio for purposes of any loss ratio guarantee.

(8) (a) The commissioner shall hold a hearing upon written request by the Attorney General. The written request shall be based upon one (1) or more of the reasons set out in subsection (3) of this section and shall state the applicable reasons.

(b) An insurer may request a hearing, pursuant to KRS 304.2-310, with regard to any action taken by the commissioner under this section as to the disapproval of rates or an order of a retroactive reduction of rates.

(c) The hearing shall be a public hearing conducted in accordance with KRS 304.2-310.

➔Section 19. KRS 304.17A-005 is amended to read as follows:

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

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively

markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

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

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

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

(7) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(8) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;
9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or
11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program.

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (14) of this section;

(9) "Dependent" means any individual who is or may become eligible for coverage

under the terms of an individual or group health benefit plan because of a relationship to a participant;

(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;

(11) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(12) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in subsection (30) of this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in subsection (5) of this section shall be treated as a large group under this subtitle;

(13) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(14) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.

1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(18) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

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

(20) "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting

criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(22) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income,

fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, or limited health service benefit plans;

(23) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist or home medical equipment and services provider as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Advanced practice registered nurses licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in

accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(25) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(26) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws;

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

(28) "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(29) "Kentucky Access" has the meaning provided in ***subsection (15) of Section 4 of this Act***~~[KRS 304.17B-001(17)]~~;

(30) "Large group" means:

(a) An employer with fifty-one (51) or more employees;

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) An employer-organized association that is a bona fide association as defined in subsection (5) of this section;

(31) "Managed care" means systems or techniques generally used by third-party payors

or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(32) "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(33) "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of the employer or members of the organization, or whose beneficiaries may be eligible to receive any benefit as established in Section 3(7) of ERISA;

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

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

(36) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

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

(38) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(39) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(40) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(41) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(42) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members;

(43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) "Telehealth" has the meaning provided in KRS 311.550.

➔Section 20. KRS 304.17A-150 is amended to read as follows:

(1) On and after July 15, 1995, it is an unfair trade practice for an insurer, agent, broker, or any other person in the business of marketing and selling health plans, to commit or perform any of the following acts:

(a) Encourage individuals or groups to refrain from filing an application for coverage with the insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(b) Encourage or direct individuals or groups to seek coverage from another

insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(c) Encourage an employer to exclude an employee from coverage.

The provisions of this subsection shall not apply to information provided regarding the established geographic service area of an insurer.

(2) It is an unfair trade practice for an insurer to compensate an agent, broker, or any other person in the business of marketing and selling health plans on the basis of the health status, claims experience, industry, occupation, or geographic location of the insured or prospective insured, except as provided in ***Sections 4 to 14 of this Act***~~[KRS 304.17B-001 to 304.17B-031]~~.

(3) It shall constitute an unfair trade practice for any insurer, insurance agent, or third-party administrator to refer an individual to Kentucky Access, or to arrange for an individual to apply to Kentucky Access, for the purpose of separating an individual from group health insurance coverage.

(4) It is an unfair trade practice for an insurer that offers multiple health benefit plans to require a health care provider, as a condition of participation in a health benefit plan of the insurer, to participate in any of the insurer's other health benefit plans. In addition to the proceedings and penalties provided in this chapter for violation of this provision, a contract provision violating this subsection is void.

(5) It is an unfair trade practice for an insurer not to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health-care provider from the insurer.

(6) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment under ***Section 9 of this Act***~~[KRS 304.17B-021]~~. As an alternative, the commissioner may levy a civil penalty on any member insurer that fails to pay the assessment when due. The civil penalty shall not exceed five percent (5%) of the

unpaid assessment per month, but no civil penalty shall be less than one hundred dollars ($100) per month.

(7) The remedy provided by KRS 304.12-120 shall be available for conduct proscribed by this section.

(8) It is an unfair claims settlement practice for any person to make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made in instances in which the insured has a liability under the policy beyond his or her copayment or deductible.

(9) It is an unfair trade practice to impose requirements in a provider contract or agreement with a doctor of chiropractic licensed pursuant to KRS Chapter 312 that restrict, reduce, or negate the benefits that are otherwise provided to a person covered under a health benefit plan. Nothing in this subsection shall be construed to prevent an insurer from performing a utilization review in accordance with KRS 304.17A-600 to 304.17A-633.

➔Section 21. KRS 304.17A-250 is amended to read as follows:

(1) The commissioner shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan. After July 15, 2004, insurers may offer the standard health benefit plan in the individual or small group markets. Except as may be necessary to coordinate with changes in federal law, the commissioner shall not alter, amend, or replace the standard health benefit plan more frequently than annually.

(2) If offered, the standard health benefit plan may be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of ***Section 9 of this Act***~~[KRS 304.17B-021]~~ for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who offers the standard health benefit plan may offer the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are more generous to the applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6) All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(7) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the commissioner as provided in KRS 304.18-085.

(8) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care

provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(9) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(10) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a properly completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured~~[with a disclosed high-cost condition as specified in KRS 304.17B-001 or]~~ for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(11) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health

department.

(12) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

➔Section 22. KRS 304.17A-320 is amended to read as follows:

(1) No employer-organized association shall in this state self-insure in order to provide health benefit plans for its members unless it holds a certificate of filing from the commissioner.

(2) To qualify for a certificate of filing and to maintain a certificate of filing, the employer-organized association shall comply with the provisions of KRS 304.17A-800 to 304.17A-844 to the extent not in conflict with the expressed provisions of this section.

(3) Each association that holds a certificate of filing from the commissioner shall be subject to the following:

(a) All assessments placed on insurers under ***Section 9 of this Act***~~[KRS 304.17B-021]~~;

(b) All rating restrictions placed on employer-organized associations under KRS 304.17A-0954;

(c) All rate review requirements placed on insurers under this subtitle;

(d) All data collection requirements placed on insurers under this subtitle; and

(e) Provisions of Subtitle 12 of this chapter that apply to health insurers.

(4) Each association that holds a certificate of filing from the commissioner shall notify

its members that health benefit plans issued to its members through the association are not protected through the Kentucky Life and Health Insurance Guaranty Association.

(5) Under the provisions of KRS 304.17A-840, the commissioner may revoke the certificate of filing of any association. A violation of any provision of this section shall be deemed a violation of KRS 304.17A-800 to 304.17A-844 for purposes of KRS 304.17A-840.

➔Section 23. KRS 304.32-270 is amended to read as follows:

Nonprofit hospital, medical-surgical, dental, and health service corporations shall be subject to the provisions of this subtitle, and to the following provisions of this code, to the extent applicable and not in conflict with the express provisions of this subtitle:

(1) Subtitle 1 -- Scope -- General Definitions and Provisions;

(2) Subtitle 2 -- Commissioner of the Department of Insurance;

(3) Subtitle 7 -- Investments;

(4) Subtitle 8 -- Administration of Deposits;

(5) Subtitle 12 -- Trade Practices and Frauds;

(6) Subtitle 25 -- Continuity of Management;

(7) Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(8) Subtitle 18 -- KRS 304.18-110, 304.18-120 -- Group Conversion and KRS 304.18-045;

(9) Subtitle 4 -- Fees and Taxes;

(10) Subtitle 99 -- Penalties;

(11) Subtitle 14 -- KRS 304.14-500 to 304.14-560;

(12) Subtitle 17A -- Health Benefit Plans;

(13) ~~[Subtitle 17B -- Kentucky Access;~~

~~(14)]~~Subtitle 9 -- Agents, Consultants, Solicitors and Adjusters; and

(14)~~[(15]~~) Subtitle 3 -- Authorization of Insurers and General Requirements**;**

and to the provisions of Sections 4 to 14 of this Act relating to Kentucky Access, to the extent applicable and not in conflict with the express provisions of this subtitle.

➔Section 24. KRS 304.38-200 is amended to read as follows:

Health maintenance organizations shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(1) Subtitle 1 -- Scope -- General Definitions and Provisions;

(2) Subtitle 2 -- Commissioner of the Department of Insurance;

(3) Subtitle 3 -- Authorization of Insurers and General Requirements;

(4) Subtitle 4 -- Fees and Taxes;

(5) Subtitle 5 -- Kinds of Insurance -- Limits of Risk -- Reinsurance;

(6) Subtitle 6 -- Assets and Liabilities;

(7) Subtitle 7 -- Investments;

(8) Subtitle 8 -- Administration of Deposits;

(9) Subtitle 9 -- Agents, Consultants, Solicitors, and Adjusters;

(10) Subtitle 12 -- Trade Practices and Frauds;

(11) Subtitle 14 -- The Insurance Contract;

(12) Subtitle 17 -- Health Insurance Contracts;

(13) Subtitle 17A -- Health Benefit Plans;

(14) ~~[Subtitle 17B -- Kentucky Access;~~

~~(15)]~~ Subtitle 17C -- Limited Health Service Benefit Plans;

(15) ~~[(16)]~~ Subtitle 18 -- Group and Blanket Health Insurance;

(16) ~~[(17)]~~ Subtitle 24 -- Domestic Stock and Mutual Insurers;

(17) ~~[(18)]~~ Subtitle 25 -- Continuity of Management;

(18) ~~[(19)]~~ Subtitle 26 -- Insider Trading of Equity Securities;

(19) ~~[(20)]~~ Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(20) ~~[(21)]~~ Subtitle 37 -- Insurance Holding Company Systems;

(21)~~[(22)]~~ Subtitle 47 -- Insurance Fraud; and

(22)~~[(23)]~~ Subtitle 99 -- Penalties***;***

and to the provisions of Sections 4 to 14 of this Act relating to Kentucky Access, to the extent applicable and not in conflict with the express provisions of this subtitle.

➔Section 25. KRS 304.2-020 is amended to read as follows:

(1) The commissioner is the head of the Department of Insurance.

(2) The commissioner shall be appointed by the Governor with the consent of the Senate, for a term not to exceed four (4) years on the basis of his or her merit and fitness to perform the duties of the office as provided in KRS 12.040. If the Senate is not in session when a term expires or a vacancy occurs, the Governor shall make the appointment to take effect at once, subject to the approval of the Senate when convened. Nothing contained in this subsection shall prohibit the commissioner of the Department of Insurance from being reappointed.

(3) The following divisions are established within the Department of Insurance and shall be headed by directors appointed by the secretary of the Public Protection Cabinet with the approval of the Governor in accordance with KRS 12.050:

(a) Property and Casualty Division;

(b) Health and Life Division;

(c) Division of Financial Standards and Examination;

(d) Division of Agent Licensing;

(e) Division of Insurance Fraud Investigation;

and

(f) Consumer Protection Division~~[; and~~

~~(g) Division of Kentucky Access]~~.

➔Section 26. KRS 12.020 is amended to read as follows:

Departments, program cabinets and their departments, and the respective major administrative bodies that they include are enumerated in this section. It is not intended

that this enumeration of administrative bodies be all-inclusive. Every authority, board, bureau, interstate compact, commission, committee, conference, council, office, or any other form of organization shall be included in or attached to the department or program cabinet in which they are included or to which they are attached by statute or statutorily authorized executive order; except in the case of the Personnel Board and where the attached department or administrative body is headed by a constitutionally elected officer, the attachment shall be solely for the purpose of dissemination of information and coordination of activities and shall not include any authority over the functions, personnel, funds, equipment, facilities, or records of the department or administrative body.

I. Cabinet for General Government - Departments headed by elected officers:

(1) The Governor.

(2) Lieutenant Governor.

(3) Department of State.

(a) Secretary of State.

(b) Board of Elections.

(c) Registry of Election Finance.

(4) Department of Law.

(a) Attorney General.

(5) Department of the Treasury.

(a) Treasurer.

(6) Department of Agriculture.

(a) Commissioner of Agriculture.

(b) Kentucky Council on Agriculture.

(7) Auditor of Public Accounts.

II. Program cabinets headed by appointed officers:

(1) Justice and Public Safety Cabinet:

(a) Department of Kentucky State Police.

(b) Department of Criminal Justice Training.

(c) Department of Corrections.

(d) Department of Juvenile Justice.

(e) Office of the Secretary.

(f) Office of Drug Control Policy.

(g) Office of Legal Services.

(h) Office of the Kentucky State Medical Examiner.

(i) Parole Board.

(j) Kentucky State Corrections Commission.

(k) Office of Legislative and Intergovernmental Services.

(l) Office of Management and Administrative Services.

(m) Department for Public Advocacy.

(2) Education and Workforce Development Cabinet:

(a) Office of the Secretary.

1. Governor's Scholars Program.

(b) Office of Legal and Legislative Services.

1. Client Assistance Program.

(c) Office of Communication.

(d) Office of Budget and Administration.

1. Division of Human Resources.

2. Division of Administrative Services.

(e) Office of Technology Services.

(f) Office of Educational Programs.

(g) Office for Education and Workforce Statistics.

(h) Board of the Kentucky Center for Education and Workforce Statistics.

(i) Board of Directors for the Center for School Safety.

(j) Department of Education.

1. Kentucky Board of Education.

2. Kentucky Technical Education Personnel Board.

(k) Department for Libraries and Archives.

(l) Department of Workforce Investment.

1. Office for the Blind.

2. Office of Vocational Rehabilitation.

3. Office of Employment and Training.

a. Division of Grant Management and Support.

b. Division of Workforce and Employment Services.

c. Division of Unemployment Insurance.

(m) Foundation for Workforce Development.

(n) Kentucky Office for the Blind State Rehabilitation Council.

(o) Kentucky Workforce Investment Board.

(p) Statewide Council for Vocational Rehabilitation.

(q) Statewide Independent Living Council.

(r) Unemployment Insurance Commission.

(s) Education Professional Standards Board.

1. Division of Educator Preparation.

2. Division of Certification.

3. Division of Professional Learning and Assessment.

4. Division of Legal Services.

(t) Kentucky Commission on the Deaf and Hard of Hearing.

(u) Kentucky Educational Television.

(v) Kentucky Environmental Education Council.

(3) Energy and Environment Cabinet:

(a) Office of the Secretary.

1. Office of Legislative and Intergovernmental Affairs.
2. Office of General Counsel.
3. Office of Administrative Hearings.
4. Mine Safety Review Commission.
5. Kentucky State Nature Preserves Commission.
6. Kentucky Environmental Quality Commission.
7. Kentucky Public Service Commission.

(b) Department for Environmental Protection.

1. Office of the Commissioner.
2. Division for Air Quality.
3. Division of Water.
4. Division of Environmental Program Support.
5. Division of Waste Management.
6. Division of Enforcement.
7. Division of Compliance Assistance.

(c) Department for Natural Resources.

1. Office of the Commissioner.
2. Division of Technical and Administrative Support.
3. Division of Mine Permits.
4. Division of Mine Reclamation and Enforcement.
5. Division of Abandoned Mine Lands.
6. Division of Oil and Gas.
7. Office of Mine Safety and Licensing.
8. Division of Forestry.
9. Division of Conservation.
10. Office of the Reclamation Guaranty Fund.

(d) Department for Energy Development and Independence.

1. Division of Efficiency and Conservation.
2. Division of Renewable Energy.
3. Division of Biofuels.
4. Division of Energy Generation Transmission and Distribution.
5. Division of Carbon Management.
6. Division of Fossil Energy Development.

(4) Public Protection Cabinet.

(a) Office of the Secretary.

1. Office of Communications and Public Outreach.
2. Office of Legal Services.

a. Insurance Legal Division.

b. Charitable Gaming Legal Division.

c. Alcoholic Beverage Control Legal Division.

d. Housing, Buildings and Construction Legal Division.

e. Financial Institutions Legal Division.

(b) Crime Victims Compensation Board.

(c) Board of Claims.

(d) Kentucky Board of Tax Appeals.

(e) Kentucky Boxing and Wrestling Authority.

(f) Kentucky Horse Racing Commission.

1. Division of Licensing.
2. Division of Incentives and Development.
3. Division of Veterinary Services.
4. Division of Security and Enforcement.

(g) Department of Alcoholic Beverage Control.

1. Division of Distilled Spirits.
2. Division of Malt Beverages.

3. Division of Enforcement.

(h) Department of Charitable Gaming.

1. Division of Licensing and Compliance.

2. Division of Enforcement.

(i) Department of Financial Institutions.

1. Division of Depository Institutions.

2. Division of Non-Depository Institutions.

3. Division of Securities.

(j) Department of Housing, Buildings and Construction.

1. Division of Fire Prevention.

2. Division of Plumbing.

3. Division of Heating, Ventilation, and Air Conditioning.

4. Division of Building Code Enforcement.

(k) Department of Insurance.

1. Property and Casualty Division.

2. Health and Life Division.

3. Division of Financial Standards and Examination.

4. Division of Agent Licensing.

5. Division of Insurance Fraud Investigation.

6. Consumer Protection Division.

~~[7. Division of Kentucky Access.]~~

(l) Office of Occupations and Professions.

(5) Labor Cabinet.

(a) Office of the Secretary.

1. Division of Management Services.

2. Office of General Counsel.

(b) Office of General Administration and Program Support for Shared

Services.

1. Division of Human Resource Management.
2. Division of Fiscal Management.
3. Division of Budgets.
4. Division of Information Services.

(c) Office of Inspector General for Shared Services.

(d) Department of Workplace Standards.

1. Division of Employment Standards, Apprenticeship, and Mediation.
2. Division of Occupational Safety and Health Compliance.
3. Division of Occupational Safety and Health Education and Training.
4. Division of Workers' Compensation Funds.

(e) Department of Workers' Claims.

1. Office of General Counsel for Workers' Claims.
2. Office of Administrative Law Judges.
3. Division of Claims Processing.
4. Division of Security and Compliance.
5. Division of Information and Research.
6. Division of Ombudsman and Workers' Compensation Specialist Services.
7. Workers' Compensation Board.
8. Workers' Compensation Advisory Council.
9. Workers' Compensation Nominating Commission.

(f) Workers' Compensation Funding Commission.

(g) Kentucky Labor-Management Advisory Council.

(h) Occupational Safety and Health Standards Board.

(i) Prevailing Wage Review Board.

(j) Apprenticeship and Training Council.

(k) State Labor Relations Board.

(l) Employers' Mutual Insurance Authority.

(m) Kentucky Occupational Safety and Health Review Commission.

(6) Transportation Cabinet:

(a) Department of Highways.

1. Office of Project Development.

2. Office of Project Delivery and Preservation.

3. Office of Highway Safety.

4. Highway District Offices One through Twelve.

(b) Department of Vehicle Regulation.

(c) Department of Aviation.

(d) Department of Rural and Municipal Aid.

1. Office of Local Programs.

2. Office of Rural and Secondary Roads.

(e) Office of the Secretary.

1. Office of Public Affairs.

2. Office for Civil Rights and Small Business Development.

3. Office of Budget and Fiscal Management.

4. Office of Inspector General.

(f) Office of Support Services.

(g) Office of Transportation Delivery.

(h) Office of Audits.

(i) Office of Human Resource Management.

(j) Office of Information Technology.

(k) Office of Legal Services.

(7) Cabinet for Economic Development:

(a) Office of the Secretary.

1. Office of Legal Services.

2. Department for Business Development.

a. Office of Entrepreneurship.

i. Commission on Small Business Advocacy.

b. Office of Research and Public Affairs.

c. Bluegrass State Skills Corporation.

3. Office of Financial Services.

a. Kentucky Economic Development Finance Authority.

b. Division of Finance and Personnel.

c. Division of Network Administration.

d. Compliance Division.

e. Incentive Assistance Division.

(8) Cabinet for Health and Family Services:

(a) Office of the Secretary.

(b) Office of Health Policy.

(c) Office of Legal Services.

(d) Office of Inspector General.

(e) Office of Communications and Administrative Review.

(f) Office of the Ombudsman.

(g) Office of Policy and Budget.

(h) Office of Human Resource Management.

(i) Office of Administrative and Technology Services.

(j) ***Office of the Kentucky Health Benefit and Health Information Exchange.***

(k) Department for Public Health.

(l)~~[(k)]~~ Department for Medicaid Services.

(m)~~[(l)]~~ Department for Behavioral Health, Developmental and Intellectual Disabilities.

(n)~~[(m)]~~ Department for Aging and Independent Living.

(o)~~[(n)]~~ Department for Community Based Services.

(p)~~[(o)]~~ Department for Income Support.

(q)~~[(p)]~~ Department for Family Resource Centers and Volunteer Services.

(r)~~[(q)]~~ Kentucky Commission on Community Volunteerism and Service.

(s)~~[(r)]~~ Kentucky Commission for Children with Special Health Care Needs.

(t)~~[(s)]~~ Governor's Office of Electronic Health Information.

(9) Finance and Administration Cabinet:

(a) Office of General Counsel.

(b) Office of the Controller.

(c) Office of Administrative Services.

(d) Office of Public Information.

(e) Office of Policy and Audit.

(f) Department for Facilities and Support Services.

(g) Department of Revenue.

(h) Commonwealth Office of Technology.

(i) State Property and Buildings Commission.

(j) Office of Equal Employment Opportunity and Contract Compliance.

(k) Kentucky Employees Retirement Systems.

(l) Commonwealth Credit Union.

(m) State Investment Commission.

(n) Kentucky Housing Corporation.

(o) Kentucky Local Correctional Facilities Construction Authority.

(p) Kentucky Turnpike Authority.

(q) Historic Properties Advisory Commission.

(r) Kentucky Tobacco Settlement Trust Corporation.

(s) Kentucky Higher Education Assistance Authority.

(t) Kentucky River Authority.

(u) Kentucky Teachers' Retirement System Board of Trustees.

(v) Executive Branch Ethics Commission.

(10) Tourism, Arts and Heritage Cabinet:

(a) Kentucky Department of Travel and Tourism.

1. Division of Tourism Services.

2. Division of Marketing and Administration.

3. Division of Communications and Promotions.

(b) Kentucky Department of Parks.

1. Division of Information Technology.

2. Division of Human Resources.

3. Division of Financial Operations.

4. Division of Facilities Management.

5. Division of Facilities Maintenance.

6. Division of Customer Services.

7. Division of Recreation.

8. Division of Golf Courses.

9. Division of Food Services.

10. Division of Rangers.

11. Division of Resort Parks.

12. Division of Recreational Parks and Historic Sites.

(c) Department of Fish and Wildlife Resources.

1. Division of Law Enforcement.

2. Division of Administrative Services.
3. Division of Engineering.
4. Division of Fisheries.
5. Division of Information and Education.
6. Division of Wildlife.
7. Division of Public Affairs.

(d) Kentucky Horse Park.

1. Division of Support Services.
2. Division of Buildings and Grounds.
3. Division of Operational Services.

(e) Kentucky State Fair Board.

1. Office of Administrative and Information Technology Services.
2. Office of Human Resources and Access Control.
3. Division of Expositions.
4. Division of Kentucky Exposition Center Operations.
5. Division of Kentucky International Convention Center.
6. Division of Public Relations and Media.
7. Division of Venue Services.
8. Division of Personnel Management and Staff Development.
9. Division of Sales.
10. Division of Security and Traffic Control.
11. Division of Information Technology.
12. Division of the Louisville Arena.
13. Division of Fiscal and Contract Management.
14. Division of Access Control.

(f) Office of the Secretary.

1. Office of Finance.

2. Office of Research and Administration.

3. Office of Governmental Relations and Tourism Development.

4. Office of the Sports Authority.

5. Kentucky Sports Authority.

(g) Office of Legal Affairs.

(h) Office of Human Resources.

(i) Office of Public Affairs and Constituent Services.

(j) Office of Creative Services.

(k) Office of Capital Plaza Operations.

(l) Office of Arts and Cultural Heritage.

(m) Kentucky African-American Heritage Commission.

(n) Kentucky Foundation for the Arts.

(o) Kentucky Humanities Council.

(p) Kentucky Heritage Council.

(q) Kentucky Arts Council.

(r) Kentucky Historical Society.

1. Division of Museums.

2. Division of Oral History and Educational Outreach.

3. Division of Research and Publications.

4. Division of Administration.

(s) Kentucky Center for the Arts.

1. Division of Governor's School for the Arts.

(t) Kentucky Artisans Center at Berea.

(u) Northern Kentucky Convention Center.

(v) Eastern Kentucky Exposition Center.

(11) Personnel Cabinet:

(a) Office of the Secretary.

(b) Department of Human Resources Administration.

(c) Office of Employee Relations.

(d) Kentucky Public Employees Deferred Compensation Authority.

(e) Office of Administrative Services.

(f) Office of Legal Services.

(g) Governmental Services Center.

(h) Department of Employee Insurance.

(i) Office of Diversity and Equality.

(j) Center of Strategic Innovation.

III. Other departments headed by appointed officers:

(1) Council on Postsecondary Education.

(2) Department of Military Affairs.

(3) Department for Local Government.

(4) Kentucky Commission on Human Rights.

(5) Kentucky Commission on Women.

(6) Department of Veterans' Affairs.

(7) Kentucky Commission on Military Affairs.

(8) Office of Minority Empowerment.

(9) Governor's Council on Wellness and Physical Activity.

➔Section 27. The following KRS sections are repealed:

304.17B-011 Third-party administrator to administer Kentucky Access -- Selection and duties -- Reimbursement for expenses.

304.17B-013 Premium rates for health benefit plans under Kentucky Access.

304.17B-015 Eligibility for coverage under Kentucky Access.

304.17B-017 Department's responsibility for evaluation and revision of rates and plans offered to Kentucky Access enrollees.

304.17B-019 Types of health benefit plans to be issued under Kentucky Access.

304.17B-033 List of high-cost conditions -- Recommendations and changes -- Administrative regulations.

304.17B-035 Payment for coverage of services within scope of practice of optometrists.

304.17B-037 Limitation on amount of copayment or coinsurance charged for services rendered by chiropractor or optometrist.

➔Section 28. The General Assembly confirms Executive Order 2014-906, dated November 7, 2014, to the extent it is not otherwise confirmed or superseded by this Act.

➔Section 29. The General Assembly confirms Executive Order 2014-561, dated June 30, 2014, to the extent it is not otherwise confirmed or superseded by this Act.

➔Section 30. In order to reflect the reorganization effectuated by this Act, the reviser of statutes shall replace references in the Kentucky Revised Statutes to the agencies, subagencies, and officers affected by this Act with references to the appropriate successor agencies, subagencies, and officers established by this Act. The reviser of statutes shall base these actions on the functions assigned to the new entities in this Act and may consult with officers of the affected agencies, or their designees, to receive suggestions.