AN ACT relating to mandatory benefits for health benefit plans.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Any health benefit plan issued or renewed on or after the effective date of this Act:

(1) Shall not:

(a) Impose any of the following:

1. Any preexisting condition exclusion with respect to the plan or coverage. For purposes of this subsection, "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date;

2. Any lifetime limits on the dollar value of benefits for any insured; or

3. Any unreasonable annual limits on the dollar value of benefits for insured;

(b) Rescind any health benefit plan or coverage with respect to an insured once the insured is covered under the health benefit plan or coverage, except as authorized by KRS 304.17A-240; or

(c) Require an individual, as a condition of enrollment or continued enrollment under the policy, to pay a premium or contribution based on the individual's sex that is greater than the premium or contribution for a similarly situated individual of the opposite sex; and

(2) Shall:

(a) Provide coverage for at least the following essential health care benefits:

1. Ambulatory patient services;

2. Emergency services;

3. Hospitalization benefits;

4. Pregnancy, maternity, and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;

8. Laboratory services;

9. Preventive and wellness services and chronic disease management; and

10. Pediatric services, including oral and vision care;

(b) 1. Accept every employer and individual in the state that applies for coverage or renewal of coverage.

2. Mandated acceptance under this paragraph may be restricted to open or special enrollment periods.

3. The commissioner shall promulgate administrative regulations to establish the period restrictions allowed under subparagraph 2 of this paragraph; and

(c) Provide coverage for and not impose any cost-sharing requirements for:

1. Evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;

2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

3. With respect to infants, children, and adolescents, evidence-informed

preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, such additional preventive care and screenings not described in paragraph (a) of this subsection as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

➔Section 2. 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;

(18) ~~[(23)]~~ "Health care provider" or "provider" means any facility or service required to

be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS Chapter 315, or home medical equipment and services provider as defined pursuant to KRS 309.402, 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;]~~

(19) ~~[(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;

(20) ~~[(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;

(21) ~~[(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;

(22) ~~[(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;

(23) ~~[(29)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001~~[(17)]~~;

(24) ~~[(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;

(25) ~~[(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;

(26) ~~[(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;

(27) ~~[(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;

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

(29) ~~[(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;

(30) ~~[(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;

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

(32) ~~[(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;

(33) ~~[(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;

(34) ~~[(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;

(35) ~~[(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;

(36) ~~[(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;

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

(38) ~~[(44)]~~ "Telehealth" has the meaning provided in KRS 311.550.

➔Section 3. KRS 304.17A-095 is amended to read as follows:

(1) ~~[(a)]~~Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to any market segment ~~[other than a large group]~~shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers. The insurer shall also submit a copy of the filing to the Attorney General and shall comply with the provisions of this section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the commissioner. The insurer shall submit a new filing to reflect any material change to the previously filed and approved rate filing. For all other changes, the insurer shall submit an amendment to a previously approved rate filing.~~[~~

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

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

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

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

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

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

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

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

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

(f) The effect on the rates of any assessment made under KRS 304.17B-021; and

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

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

(5) At any time the commissioner, after a public hearing for which at least thirty (30)

days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and subscribers if the commissioner determines that the rates or fees previously approved are in violation of this chapter.

(6) ~~[Notwithstanding subsection (2) of this section,]~~Premium rates ***shall be*** ~~[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 ***that*** 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. ***Eighty percent (80%)***~~[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 ***fifty (50)***~~[ten (10)]~~ employees or for certificates issued to members of an association that offers coverage to small employers; and

(b)~~[c.]~~ ***Eighty-five percent (85%)***~~[Seventy-five percent (75%)]~~ for policies issued to ***large groups as defined in KRS 304.17A-005***~~[small groups of eleven (11) to fifty (50) employees;~~

~~6. A guarantee that the actual Kentucky loss ratio for the calendar year in which the new rates take effect, and for each year thereafter until new rates are filed, will meet or exceed the minimum loss ratio standards referred to in subparagraph 5. of this paragraph, adjusted for duration;~~

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

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

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

regulations promulgated by the commissioner.

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

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

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

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

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

(h) The insurer ~~[who elects to use the filing procedure with a minimum loss ratio guarantee]~~shall notify all policyholders of the refund calculation, the result of

the refund calculation, the percent of premium on an aggregate basis to be refunded if any, any amount of the refund attributed to the payment of interests, and an explanation of amounts less than ten dollars ($10).

(i) Notwithstanding the provisions of this subsection, an insurer may amend the policy forms used before ***the effective date of this Act***~~[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 ***required***~~[allowed]~~ under this subsection for policies issued, delivered, or renewed on or after ***the effective date of this Act***~~[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 4. KRS 304.17A-0952 is amended to read as follows:

Premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

(1) The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003.

(2) Notwithstanding the thirty-five percent (35%) variance limitation in subsection (1) of this section, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:

(a) The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;

(b) The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and

(c) The premium rate is actuarially justified and has been approved by the Department of Insurance pursuant to KRS 304.17A-095.

(3) The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business.

(4) The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate.

(5) The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:

(a) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

(b) Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and

(c) Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business.

(6) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age~~[, gender]~~, occupation or industry, and geographic area.

(7) Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group.

(8) The commissioner may approve establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the additional class would enhance the efficiency and fairness for the applicable market segment.

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).

(b) An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative cost related to the

following reasons:

1. The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans;
2. The insurer has acquired a class of business from another insurer; or
3. The insurer is offering a state-elected plan under the provisions of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201.

(c) Notwithstanding any other provision of this subsection, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected claims experience and administrative costs of the new class of business and the previous class of business.

(9) For the purpose of this section, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs.

(10) Notwithstanding any other provision of this section, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies.

(11) Nothing in this section shall be construed to prevent an insurer from offering incentives to participate in a program of disease prevention or health improvement.

➔Section 5. KRS 304.17A-0954 is amended to read as follows:

(1) For purposes of this section:

(a) "Base premium rate" has the meaning provided in KRS 304.17A-005;

(b) "Employer" means a person engaged in a trade or business who has two (2) or more employees within the state in each of twenty (20) or more calendar weeks in the current or preceding calendar year;

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

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

2. An entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and which is not insurer-controlled; or

3. Any entity which 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;

(d) "Index rate" has the meaning provided in KRS 304.17A-005.

(2) Notwithstanding any other provision of this chapter, the amount or rate of premiums for an employer-organized association health plan may be determined, subject to the restrictions of subsection (3) of this section, based upon the experience or projected experience of the employer-organized associations whose employers obtain group coverage under the plan. Without the written consent of the employer-organized association filed with the commissioner, the index rate for the employer-organized association shall be calculated solely with respect to that

employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.

(3) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized health insurance plan:

(a) The premium rates charged during a rating period to members of the employer-organized association with similar characteristics for the same or similar coverage, or the premium rates that could be charged to a member of the employer-organized association under the rating system for that class of business, shall not vary from its own index rate by more than fifty percent (50%) of its own index rate; and

(b) The percentage increase in the premium rate charged to an employer member of an employer-organized association for a new rating period shall not exceed the sum of the following:

1. The percentage change in the new business premium rate for the employer-organized association measured from the first day of the prior rating period to the first day of the new rating period;

2. Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating period of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the member as determined from the insurer's rate manual; and

3. Any adjustment due to change in coverage or change in the case characteristics of the member as determined by the insurer's rate manual.

(4) In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age~~[, gender]~~, occupation or industry,

and geographic area.

(5) For the purpose of this section, a health insurance contract that utilizes a restricted provider network shall not be considered similar coverage to a health insurance contract that does not utilize a restricted provider network if utilization of the restricted provider network results in measurable differences in claims costs.

➔Section 6. KRS 304.17A-096 is amended to read as follows:

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group, and employer-organized association markets. A basic health benefit plan shall cover 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.

(2) An insurer that offers a basic health benefit plan shall be required to offer health benefit plans as defined in KRS 304.17A-005~~[(22)]~~.

(3) An insurer in the individual, small group, or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health benefit plan shall include coverage for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic benefits as provided in KRS 304.17A-171, mammograms as provided in KRS 304.17A-133, and those mandated benefits specified under federal law.

(4) Notwithstanding any other provisions of this section, mandated benefits excluded from coverage shall not be deemed to include the payment, indemnity, or reimbursement of specified health care providers for specific health care services.

➔Section 7. KRS 304.17A-200 is amended to read as follows:

(1) An insurer that offers ***any*** health benefit plan coverage ~~[in the small group, large~~

~~group, or association market]~~may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or the dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(2) An insurer that offers health benefit plan coverage in the small group, large group, or association market shall not require any individual to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or a dependent of the individual. Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) Subject to subsections (4) to (7) of this section, each insurer that offers health benefit plan coverage in the small groups market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.

(a) Notwithstanding any other provision of this subsection, the insurer may

establish group participation rules requiring a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of those eligible for enrollment.

(b) The terms and participation rules of the group health benefit plan shall be uniformly applicable to small employers in the small group market.

(c) This subsection shall not apply to health benefit plan coverage offered by an insurer if the coverage is made available in the small group market only through one (1) or more bona fide associations.

(4) In the case of an insurer that offers health benefit plan coverage in the small group market through a network plan, the insurer may:

(a) Limit the employers that may apply for coverage to those with individuals who live, work, or reside in the service area of the network plan; and

(b) Within the service area of the network plan, deny coverage to employers if the insurer has demonstrated to the commissioner that:

1. The network plan will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

2. The insurer is applying this denial uniformly to all employers.

(5) An insurer, upon denying health benefit plan coverage in any service area in accordance with subsection (4) of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty (180) days after the date the coverage is denied.

(6) An insurer may deny health benefit plan coverage in the small group market if the insurer has demonstrated to the commissioner that:

(a) The insurer does not have the financial reserves necessary to underwrite additional coverage; and

(b) The insurer is applying this denial uniformly to all employers in the small

group market.

(7) An insurer, upon denying health benefit plan coverage in connection with group health plans in accordance with subsection (6) of this section, shall not offer coverage in the small group market for a period of one hundred eighty (180) days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(8) A health benefit plan issued as an individual policy to individual employees or their dependents through or with the permission of a small employer shall be issued on a guaranteed-issue basis to all full-time employees~~[and shall comply with the pre-existing condition provisions of KRS 304.17A-220]~~.

(9) (a) In connection with the offering of any health benefit plan to a small employer, an insurer:

1. Shall make a reasonable disclosure to a small employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this subsection; and
2. Upon request of a small employer, provide the information described in paragraph (b) of this subsection.

(b) Subject to paragraph (c) of this subsection, with respect to an insurer offering a health benefit plan to a small employer, information described in this subsection is information concerning:

1. The provisions of the coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates;
2. The provisions of the health benefit plan relating to renewability of coverage; ***and***
3. ~~[The provisions of the health benefit plan relating to any preexisting condition exclusion; and~~

~~4.]~~The benefits and premiums available under all health benefit plans for which the small employer is qualified.

(c) Information described in paragraph (b) of this subsection shall be provided to a small employer in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform a small employer of his or her rights and obligations under the health benefit plan.

(d) An insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

➔Section 8. KRS 304.17A-220 is amended to read as follows:

(1) All group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with the provisions of this section.

(2) ~~Subject to subsection (8) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a pre-existing condition exclusion only if:~~

~~(a) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. For purposes of this paragraph:~~

~~1. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and~~

~~2. The six (6) month period ending on the enrollment date begins on the six (6) month anniversary date preceding the enrollment date;~~

~~(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;~~

~~(c) 1. The period of any pre-existing condition exclusion that would otherwise~~

~~apply to an individual is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under subsection (3) of this section; and~~

~~2. Except for ineligible individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and~~

~~(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.~~

~~(3) In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one (1) or more types of creditable coverage. For purposes of counting creditable coverage:~~

~~(a) If on a particular day the individual has creditable coverage from more than one (1) source, all the creditable coverage on that day is counted as one (1) day;~~

~~(b) Any days in a waiting period for coverage are not creditable coverage;~~

~~(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and~~

~~(d) Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred.~~

~~(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.~~

~~(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or evidence of creditable coverage.~~

~~(6) For purposes of this section:~~

~~(a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan;~~

~~(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change;~~

~~(c) "First day of coverage" means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;~~

~~(d) "Late enrollee" means~~ an individual whose enrollment in a plan is a late

enrollment;

~~(e) "Late enrollment" means enrollment of an individual under a group health plan other than:~~

~~1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or~~

~~2. Through special enrollment;~~

~~(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable coverage; and~~

~~(g) "Waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:~~

~~1. If the application results in coverage, the date coverage begins; or~~

~~2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.~~

~~(7) (a) 1. Except as otherwise provided under subsection (3) of this section, for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.~~

~~2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section~~

~~based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.~~

~~3. In the case of an election with respect to a group health plan under subparagraph 2. of this paragraph, whether or not health insurance coverage is provided in connection with the plan, the plan shall:~~

~~a. Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made this election; and~~

~~b. Include in these statements a description of the effect of this election.~~

~~(b) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (9) of this section or in such other manner as may be specified in administrative regulations.~~

~~(8) (a) Subject to paragraph (c) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who, within thirty (30) days after birth, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child.~~

~~(b) Subject to paragraph (c) of this subsection, a group health plan, and a health~~

~~insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, within thirty (30) days after the adoption or placement for adoption, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child. This shall not apply to coverage before the date of the adoption or placement for adoption.~~

~~(c) A group health plan may not impose any pre-existing condition exclusion relating to pregnancy.~~

~~(d) A group health plan may not impose a pre-existing condition exclusion relating to a condition based solely on genetic information. If an individual is diagnosed with a condition, even if the condition relates to genetic information, the insurer may impose a pre-existing condition exclusion with respect to the condition, subject to other requirements of this section.~~

~~(e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.~~

~~(9) (a) 1. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide a certificate of creditable coverage as described in subparagraph 2. of this subsection. A certificate of creditable coverage shall be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the following events:~~

~~a. At the time an individual ceases to be covered under a health~~

~~benefit plan or otherwise becomes eligible under a COBRA continuation provision;~~

~~b. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision; and~~

~~c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision a. or b. of this subparagraph, whichever is later.~~

~~The certificate of creditable coverage as described under subdivision a. of this subparagraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.~~

~~2. The certification described in this subparagraph is a written certification of:~~

~~a. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the COBRA continuation provision; and~~

~~b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.~~

~~3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.~~

~~(b) In the case of an election described in subsection (7)(a)2. of this section by a~~

~~group health plan or health insurance insurer, if the plan or insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (a) of this subsection:~~

~~1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or insurer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and~~

~~2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.~~

~~(10)~~ (a) A group health plan, and a health insurance insurer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of that employee if the dependent is eligible but not enrolled for coverage under these terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child, death of the employee, termination of employment, reduction in the number of hours of employment, employer contributions toward the coverage were terminated, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

c. Was offered through a health maintenance organization or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

4. An insurer shall allow an employee and dependent a period of at least thirty (30) days after an event described in this paragraph has occurred to request enrollment for the employee or the employee's dependent. Coverage shall begin no later than the first day of the first calendar month beginning after the date the insurer receives the request for special enrollment.

(b) A dependent of a current employee, including the employee's spouse, and the

employee each are eligible for enrollment in the group health plan subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee if the requirements of paragraph (a) of this subsection are satisfied.

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

the group health plan shall provide for a dependent special enrollment period described in subparagraph 2. of this paragraph during which the person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

2. A dependent special enrollment period under this subparagraph shall be a period of at least thirty (30) days and shall begin on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the coverage of the

dependent shall become effective:

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

~~[(11) (a) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:~~

~~1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;~~

~~2. The period is applied uniformly without regard to any health status-related factors; and~~

~~3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.~~

~~(b) 1. For purposes of this section, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period.~~

~~2. This period shall begin on the enrollment date.~~

~~3. An affiliation period under a plan shall run concurrently with any waiting period under the plan.~~

~~(c) A health maintenance organization described in paragraph (a) of this subsection may use alternative methods other than those described in that paragraph to address adverse selection as approved by the commissioner.]~~

➔Section 9. 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 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 10. KRS 304.17A-256 is amended to read as follows:

~~[(1)]~~All group health benefit plans which provide dependent benefits shall offer the master policyholder ~~[the following two (2) options to purchase]~~coverage for an unmarried dependent child~~[:~~

~~(a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and~~

~~(b) Coverage]~~ until age ***twenty-six (26)*** ~~[twenty-five (25)]~~.

~~[(2) The offer of coverage under paragraph (b) of subsection (1) of this section shall include a disclaimer that selecting either option may have tax implications.]~~

➔Section 11. KRS 304.17A-706 is amended to read as follows:

(1) An insurer may contest a clean claim only in the following instances:

(a) The insurer has reasonable documented grounds to believe that the clean claim involves ~~[a preexisting condition,]~~coordination of benefits within the meaning of KRS 304.18-085, or that another insurer is primarily responsible for the claim;

(b) The insurer will conduct a retrospective review of the services identified on the claim;

(c) The insurer has information that the claim was submitted fraudulently; or

(d) The covered person's or group's premium has not been paid.

(2) (a) If an insurer requires a provider to submit health claim attachments to the claim before the claim will be paid, the insurer shall identify the specific required health claim attachments in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide sixty (60) days' advance written notice of modifications to the

provider manual that materially change the type or content of the health claim attachments or other documents to be submitted.

(b) If a provider submits a clean claim with the required health claim attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in KRS 304.17A-702.

(c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:

1. Notify the provider, in writing or electronically within the claims payment time frame established in KRS 304.17A-702, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim;

2. Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and

3. Subject to paragraph (d) of this subsection, add interest to the amount of the claim, to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with KRS 304.17A-730, accruing from the appropriate claim payment time frame established in KRS 304.17A-613 after the claim was received by the insurer through the date upon which the claim is paid.

(d) If the provider fails to submit the information requested under subparagraph (c) 1. of this subsection within fifteen (15) business days from the date of the receipt of the notice, the insurer shall not be required to pay interest.

(3) (a) If a claim or portion thereof is contested by an insurer on the basis that the

insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, or if the insurer contests the claim on the reasonable and documented belief that the claim involves the coordination of benefits within the meaning of KRS 304.18-085~~[, or questions of pre-existing conditions]~~, the insurer shall, within the applicable claims payment time frame established in KRS 304.17A-702, provide written or electronic notice to the provider, covered person, group policyholder, or other insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed.

(b) The insurer shall pay or deny the claim within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection. If the insurer does not receive the additional information described in paragraph (a) of this subsection within fifteen (15) business days from the date of receipt of the notice set forth in paragraph (a) of this subsection, the insurer may deny the claim. Any claim denied under this paragraph may be resubmitted by the provider and any resubmitted claim shall not be denied on the basis of timeliness if the resubmitted claim is made with the timeframe for submitting claims established by the insurer beginning on the date of denial.

➔Section 12. KRS 304.18-114 is amended to read as follows:

(1) As used in this section:

(a) "Conversion health insurance coverage" means a health benefit plan meeting the requirements of this section and regulated in accordance with Subtitles 17 and 17A of this chapter;

(b) "Group policy" has the meaning provided in KRS 304.18-110; and

(c) "Medicare" has the meaning provided in KRS 304.18-110.

(2) An insurer providing group health insurance coverage shall offer a conversion health insurance policy, by written notice, to any group member terminated under

the group policy for any reason. The insurer shall offer a conversion health insurance policy substantially similar to the group policy. The former group member shall meet the following conditions:

(a) The former group member had been a member of the group and covered under any health insurance policy offered by the group for at least three (3) months;

(b) The former group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (5) of this section; and

(c) The former group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (5) of this section.

(3) An insurer shall offer the following terms of conversion health insurance coverage:

(a) Conversion health insurance coverage shall be available without evidence of insurability~~[and may contain a pre-existing condition limitation in accordance with KRS 304.17A-230]~~;

(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:

1. The effective date of the conversion policy; or

2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;

(c) The conversion health insurance policy shall cover the former group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated.

(d) The effective date of the conversion health insurance policy shall be the date of termination of coverage under the group policy; and

(e) The conversion health insurance policy shall provide benefits substantially

similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120 and any administrative regulations promulgated thereunder.

(4) Conversion health insurance coverage need not be granted in the following situations:

(a) On the effective date of coverage, the applicant is or could be covered by Medicare;

(b) On the effective date of coverage, the applicant is or could be covered by another group coverage (insured or uninsured) or, the applicant is covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or

(c) The issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection.

(5) Notice of the right to conversion health insurance coverage shall be given as follows:

(a) For group policies delivered, issued for delivery, or renewed after July 15, 2002, the insurer shall give written notice of the right to conversion health insurance coverage to any former group member entitled to conversion coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group, upon termination of the former group member's continued group health insurance coverage pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-005(7), or upon termination of the group policy for any reason. The written notice shall clearly explain the former group member's right to a conversion policy.

(b) The thirty-one (31) day period of subsection (2)(b) of this section shall not begin to run until the notice required by this subsection is mailed or delivered to the last known address of the former group member.

(c) If a former group member becomes entitled to obtain conversion health insurance coverage, pursuant to this section, and the insurer fails to give the former group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of conversion rights to the former group member and such former group member shall have an additional period within which to exercise his conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the former group member shall constitute the giving of notice for the purpose of this paragraph. If a former group member makes application and pays the premium, for conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage. However, nothing in this subsection shall require an insurer to give notice or provide conversion coverage to a former group member ninety (90) days after termination of the former group member's group coverage.

➔Section 13. KRS 304.17B-001 is amended to read as follows:

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

(1) "Administrator" is defined in KRS 304.9-051~~[(1)]~~;

(2) "Agent" 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 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" 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;

(9) "Enrollee" means a person who is enrolled in a health benefit plan offered under Kentucky Access;

(10) "Eligible individual" is defined in KRS 304.17A-005~~[(11)]~~;

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

~~(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;~~

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

(12)~~[(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;

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

(14) ~~[(16)]~~ "Insurer" is defined in KRS 304.17A-005~~[(27)]~~;

(15) ~~[(17)]~~ "Kentucky Access" means the program established in accordance with KRS 304.17B-001 to 304.17B-031;

(16) ~~[(18)]~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

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

(18) ~~[(20)]~~ "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in KRS 304.17B-003(5);

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

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

(21) ~~[(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);]~~

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

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

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

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

➔Section 14. KRS 304.17B-007 is amended to read as follows:

In its duties to operate and administer Kentucky Access, the 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 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;

(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 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;

(11) Conduct periodic audits to assure the general accuracy of the financial and claims data submitted to the department and be subject to an annual audit of its operations;

(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 department;

(15) Assess insurers and stop-loss carriers in accordance with KRS 304.17B-021;

(16) ~~[Reimburse GAP participating insurers for GAP losses pursuant to KRS 304.17B-021;~~

~~(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.

(17)~~[(18)]~~ Be audited by the Auditor of Public Accounts;

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

(19)~~[(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

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

➔Section 15. KRS 304.17B-015 is amended to read as follows:

(1) Any individual who is an eligible individual and a resident of Kentucky is eligible for coverage under Kentucky Access, except as specified in paragraphs (a), (b), (d), and (e) of subsection (4) of this section.

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky

Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in KRS 304.17B-001.

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3) year period and may be used by the enrollee to obtain insurance in the regular individual market.

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) 1. The individual has, or is eligible for, on the effective date of coverage under Kentucky Access, substantially similar coverage under another contract or policy~~[, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section]~~; or

2. For individuals meeting the requirements of KRS 304.17A-005(11), the individual has, or is eligible for, on the effective date of coverage under Kentucky Access, coverage under a group health plan.

An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible for" includes any individual and an individual's spouse or dependent who was eligible for

coverage but waived that coverage. That individual and the individual's spouse or dependent shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the department;

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs; or

(f) The individual's premium, deductible, coinsurance, or copayment is partially or entirely paid or reimbursed by an individual or entity other than the individual or the individual's parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, grandchild, guardian, or court-appointed payor.

(5) The coverage of any person who ceases to meet the requirements of this section or the requirements of any administrative regulation promulgated under this subtitle may be terminated.

➔Section 16. KRS 304.17B-019 is amended to read as follows:

(1) Kentucky Access shall offer at least three (3) health benefit plans to enrollees, which shall be similar to the health benefit plans currently being marketed to individuals in the individual market.

(2) At least one (1) plan shall be offered in a traditional fee-for-service form. At least

one (1) plan may be offered in a managed-care form at such time as the department can establish an appropriate provider network in available service areas.

(3) The department shall provide for utilization review and case management for all health benefit plans issued under Kentucky Access.

(4) The department shall review and compare health benefit plans provided under Kentucky Access to health benefit plans provided in the individual market. Based on the review, the department may amend or replace the health benefit plans issued under Kentucky Access.

(5) Individuals who apply and are determined eligible for health benefit plans issued under Kentucky Access shall have coverage effective the first day of the month after the application month.

(6) For eligible individuals, health benefit plans issued under Kentucky Access shall not impose any pre-existing condition exclusions.~~[In all other cases, a pre-existing condition exclusion may be imposed in accordance with KRS 304.17A-230.]~~

(7) Health benefit plans issued under Kentucky Access shall be guaranteed renewable except as otherwise specified in KRS 304.17B-015 and KRS 304.17A-240.

(8) All health benefit plans issued under Kentucky Access shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue under the same or a different contract.

(9) Health benefit plans issued under Kentucky Access shall coordinate benefits with other health benefit plans and be the payor of last resort.

(10) Health benefit plans issued under Kentucky Access shall pay covered benefits up to a lifetime limit of two million dollars ($2,000,000) per covered individual. The maximum limit under this subsection may be increased by the department.

➔Section 17. KRS 304.17B-021 is amended to read as follows:

(1) 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 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 department, in a form and at the time as

the 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 department may require.

(3) As part of the assessment process, the 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; ***and***

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

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

(5) The 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 department shall also determine the amount of the actual guaranteed acceptance program plan losses for each calendar year. The 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 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 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 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 department shall calculate the net amount owed to or to be received from the fund, and the 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 this chapter.

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

(8) ~~[(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.

(9) ~~[(11)]~~ Assessments on health benefit plan premiums that are required under 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.

(10) ~~[(12)]~~ The 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 KRS 304.17B-001 to 304.17B-031. As used in this subsection, "future losses" may include reserves for incurred but not reported claims.

(11) ~~[(13)]~~ The 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.

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

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

➔Section 18. KRS 304.17B-033 is amended to read as follows:

(1) No less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established under KRS 304.17B-001~~[(14)]~~ and recommend changes to the commissioner. The commissioner may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the commissioner deems appropriate. The council, in making recommendations, and the commissioner, in making changes, shall consider, among other things, actual claims and losses on each diagnosis and advances in treatment of high-cost conditions.

(2) The commissioner may by administrative regulation add to or delete from the list of high-cost conditions for Kentucky Access.

➔Section 19. KRS 304.17C-010 is amended to read as follows:

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

(1) "At the time of enrollment" means the same as defined in KRS 304.17A-005~~[(2)]~~;

(2) "Enrollee" means an individual who is enrolled in a limited health service benefit plan;

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005~~[(23)]~~;

(4) "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, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

(5) "Limited health service benefit plan" means any policy or certificate that provides services for dental, vision, mental health, substance abuse, chiropractic, pharmaceutical, podiatric, or other such services as may be determined by the commissioner to be offered under a limited health service benefit plan. A limited health service benefit plan shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the plan.

➔Section 20. KRS 304.38A-010 is amended to read as follows:

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

(1) "Enrollee" means an individual who is enrolled in a limited health services benefit plan;

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in KRS 304.17C-010 unless exempted by the commissioner;

(3) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, chiropractic services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the limited health services set forth in this subsection;

(4) "Limited health service contract" means any contract entered into by a limited health service organization with a policyholder to provide limited health services;

(5) "Limited health service organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange limited health service or services to enrollees. A limited health service organization does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited health service organization, health maintenance organization, or a health insurer; and

(6) "Provider" means the same as defined in KRS 304.17A-005~~[(23)]~~.

➔Section 21. KRS 304.39-241 is amended to read as follows:

An insured may direct the payment of benefits among the different elements of loss, if the direction is provided in writing to the reparation obligor. A reparation obligor shall honor the written direction of benefits provided by an insured on a prospective basis. The insured may also explicitly direct the payment of benefits for related medical expenses already paid arising from a covered loss to reimburse:

(1) A health benefit plan as defined by KRS 304.17A-005~~[(22)]~~;

(2) A limited health service benefit plan as defined by KRS 304.17C-010;

(3) Medicaid;

(4) Medicare; or

(5) A Medicare supplement provider.

➔Section 22. The following KRS sections are repealed:

304.17A-230 Pre-existing condition exclusion in individual market -- Prohibition against use of genetic information -- Administrative regulations.

304.17A-410 Definitions for KRS 304.17A-400 to 304.17A-480.

304.17A-430 Criteria for program plan -- Alternative underwriting.

304.17A-450 Cost-containment feature requirement for program plans.

304.17B-023 Duties of GAP participating insurer and department to report and to provide information -- Payment of GAP losses -- Examination of insurers to determine accuracy of information provided.

304.17B-025 Enrollee's option to renew health benefit plan -- Guaranteed Acceptance Program to remain in effect with certain exceptions.