AN ACT relating to mandatory benefits for health benefit plans.

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

➔Section 1. KRS 304.17A-200 is amended to read as follows:

(1) An insurer that offers health benefit plan coverage in ***any market, including*** the small group, large group,~~[or]~~ association***, employer-organized association, or individual*** market***, shall***~~[may]~~ not establish rules for eligibility***, including continued 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***; or***

(i) Any other health status-related factor that is determined appropriate by the commissioner.

(2) ***(a)*** An insurer that offers health benefit plan coverage in ***any market, including*** the small group, large group,~~[or]~~ association***, employer-organized association, or individual*** market**,** shall not require any individual***, as a condition of enrollment or continued enrollment under the plan,*** 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.

(b) An insurer that offers group health benefit plan coverage shall not adjust premium or contribution amounts for the group covered under the plan on the basis of genetic information.

(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 2. 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 (e) 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 (e) 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 3. KRS 304.17A-230 IS REPEALED AND REENACTED TO READ AS FOLLOWS:

(1) For purposes of this section, "preexisting condition exclusion" means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that a condition was present before the effective date of coverage, or if coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits

applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of denial.

(2) An insurer that offers health benefit plan coverage in any market, including the small group, large group, association, employer-organized association, or individual market, shall not impose any preexisting condition exclusion.

➔Section 4. KRS 304.17A-155 is amended to read as follows:

(1) No health benefit plan shall deny coverage, refuse to issue or renew, cancel or otherwise terminate, restrict, or exclude any person from any health benefit plan issued or renewed on or after July 15, 1998, on the basis of the applicant's or insured's status as a victim of domestic violence and abuse as defined in KRS 403.720.

(2) No health benefit plan shall deny a claim on the basis of the insured's status as a victim of domestic violence.

~~[(3) Domestic violence shall not be considered to be a preexisting condition.]~~

➔Section 5. 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 6. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) ~~[The health benefit plan imposes the maximum pre-existing condition~~

~~exclusion permitted under KRS 304.17A-200;~~

~~(d) [~~The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(d)~~[(e)]~~ The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high-risk individuals rather than using the criteria established in KRS 304.17A-005

and 304.17A-280 for high-cost conditions.

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

➔Section 7. 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 ***the*** ~~[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 ***paragraph***~~[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 8. 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)]~~;

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

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

(16) "Insurer" is defined in KRS 304.17A-005(29);

(17) "Kentucky Access" means the program established in accordance with KRS

304.17B-001 to 304.17B-031;

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

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

(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);

(21) "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

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

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

(24) "Office" means the Office of Health Data and Analytics in the Cabinet for Health and Family Services;

(25) "Pre-existing condition exclusion" is defined in ***Section 3 of this Act***~~[KRS 304.17A-220(6)]~~;

(26) "Standard health benefit plan" means a health benefit plan that meets the requirements of KRS 304.17A-250;

(27) "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(28) "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employer-controlled or bona fide associations; and

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

➔Section 9. 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 Office of Health Data and Analytics can establish an appropriate provider network in available service areas.

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

(4) The office 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 office 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 office.

➔Section 10. 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 11. The provisions of this Act apply to all health benefit plans issued or renewed on or after January 1, 2021.

➔Section 12. This Act takes effect on January 1, 2021.