AN ACT relating to consumer protections in health insurance.

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:

(1) As used in this section, "health benefit plan" has the same meaning as in KRS 304.17A-005, except the term includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.

(2) A premium rate for a health benefit plan originally issued on or after January 1, 2014, to an individual or small group shall be subject to the following provisions:

(a) The rate shall vary with respect to the particular plan only by the following case characteristics:

1. Family composition;

2. Geographic region;

3. Age, except that the ratio of the highest rate factor to the lowest rate factor shall not exceed three to one (3:1); and

4. Tobacco use, except that the ratio of the highest rate factor to the lowest rate factor shall not exceed one and four-tenths to one (1.4:1); and

(b) The commissioner may promulgate an administrative regulation to establish the following:

1. The family composition tiers for purposes of paragraph (a)1. of this subsection;

2. The geographic regions for purposes of paragraph (a)2. of this subsection; and

3. The age bands for purposes of paragraph (a)3. of this subsection.

➔SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304

IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "health benefit plan" has the same meaning as in KRS 304.17A-005, except the term includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.

(2) An insurer offering a health benefit plan in the group or individual market shall continue to make coverage available for an adult child until the attainment of age twenty-six (26).

(3) Nothing in this section shall require an insurer to make coverage available for the child of a child receiving dependent coverage under a health benefit plan.

➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "health benefit plan" has the same meaning as in KRS 304.17A-005, except the term includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.

(2) Except as provided in subsection (3) of this section, an insurer offering a health benefit plan shall provide benefits for, and shall not impose any cost-sharing requirements on, preventive services, including:

(a) 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 with respect to the individual involved, except as provided in 45 C.F.R. sec. 147.130, as amended;

(b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the federal Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices with respect to the individual involved if it is listed on the immunization

schedules of the federal Centers for Disease Control and Prevention;

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration; and

(d) With respect to women, to the extent not described in paragraph (a) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the federal Health Resources and Services Administration.

(3) (a) Subsection (2) of this section shall not apply to:

1. A health benefit plan originally issued prior to March 23, 2010; or

2. Services delivered by an out-of-network provider if a health benefit plan utilizes a network of providers.

(b) Student administrative health fees, as defined in 45 C.F.R. sec. 147.145, as amended, shall not be considered a cost-sharing requirement under subsection (2) of this section.

➔Section 4. KRS 304.17A-200 is amended to read as follows:

(1) ***(a) As used in this subsection, "health benefit plan" has the same meaning as in KRS 304.17A-005, except the term includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.***

(b) For plans issued on or after January 1, 2014, an insurer that offers health benefit plan coverage in the small group, large group,~~[or]~~ association***, or individual*** market 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:

1. ~~[(a)]~~ Health status;

2. ~~[(b)]~~ Medical condition, including both physical and mental illness;

3. ~~[(c)]~~ Claims experience;

4. ~~[(d)]~~ Receipt of health care;

5. ~~[(e)]~~ Medical history;

6. ~~[(f)]~~ Genetic information;

7. ~~[(g)]~~ Evidence of insurability, including conditions arising out of acts of domestic violence; and

8. ~~[(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;
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 5. KRS 304.17-030 is amended to read as follows:

Except as provided in Section 2 of this Act, no policy of health insurance shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this title, and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, unmarried dependent children to age nineteen (19), 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 any other person dependent upon the policyholder as provided pursuant to KRS 304.17-310;

(4) The style, arrangement, and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred and twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name on title of the policy, the brief

description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and other than those contained in KRS 304.17-050 to 304.17-290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and indorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks~~[,]~~ or short-rate table filed with the commissioner.

➔Section 6. KRS 304.17-310 is amended to read as follows:

(1) Family expense health insurance is that provided under a policy issued to one (1) of the family members insured, who shall be deemed the policyholder, covering any two (2) or more eligible members of a family, including husband, wife, unmarried dependent children, to age nineteen (19), 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 any other person dependent upon the policyholder. Any authorized health insurer may issue the insurance.

(2) An individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state more than 120 days after June 13, 1968, which provides that coverage of a dependent child shall

terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of an intellectual or physical disability and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer or corporation by the policyholder or subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(3) ***Except as provided in Section 2 of this Act,*** insurers offering family expense health insurance shall offer the applicant the option to purchase coverage for unmarried dependent children until age twenty-five (25).

➔Section 7. KRS 304.17A-0952 is amended to read as follows:

Except as provided in Section 1 of this Act, 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) ***(a)*** 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.

(b)~~[(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%).

(c)~~[(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.

(d)~~[(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 ***subsection***~~[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 8. The following KRS section is repealed:

304.17A-256 Options for dependent coverage under group health benefit plans -- Disclaimer.