1 AN ACT relating to consumer protections in health insurance.

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

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

5 ***(1) For purposes of this section:***

6 ***(a) "Essential health benefits" means, with respect to any health benefit plan,***
7 ***coverage that provides the benefits that are determined by the commissioner***
8 ***in accordance with subsection (3) of this section;***

9 ***(b) "Pre-existing condition exclusion":***

10 ***1. Means a limitation or exclusion of benefits, including a denial of***
11 ***coverage, based on the fact that a condition was present before the***
12 ***effective date of coverage, or if coverage is denied, the date of denial,***
13 ***whether or not any medical advice, diagnosis, care, or treatment was***
14 ***recommended or received before that day; and***

15 ***2. Includes any limitation or exclusion of benefits applicable to an***
16 ***individual as a result of information relating to an individual's health***
17 ***status before the individual's effective date of coverage, or if coverage***
18 ***is denied, the date of denial; and***

19 ***(c) "Reviser of statutes" means the person appointed under KRS 7.140.***

20 ***(2) Notwithstanding any other state law:***

21 ***(a) An insurer that offers health benefit plan coverage in any market, including***
22 ***the small group, large group, association, employer-organized association,***
23 ***or individual market, shall:***

24 ***1. Not establish rules for eligibility, including continued eligibility, of***
25 ***any individual to enroll under the terms of the plan based on any of***
26 ***the following health status-related factors in relation to the individual***
27 ***or a 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*
8 *of domestic violence;*
9 *h. Disability;*
10 *i. Sex and gender; or*
11 *j. Any other health status-related factor that is determined*
12 *appropriate by the commissioner;*
13 *2. Not require any individual, as a condition of enrollment or continued*
14 *enrollment under the plan, to pay a premium or contribution which is*
15 *greater than the premium or contribution, or be subject to benefits*
16 *coverage that is different than the benefits coverage, for a similarly*
17 *situated individual enrolled in the plan on the basis of any health*
18 *status-related factor identified in subparagraph 1. of this paragraph in*
19 *relation to the individual or a dependent of the individual;*
20 *3. Not impose any pre-existing condition exclusion with respect to such*
21 *plan or coverage;*
22 *4. Provide coverage for essential health benefits with respect to such*
23 *plan or coverage; and*
24 *5. Not establish lifetime or annual limits on the dollar value of essential*
25 *health benefits for any insured covered under the plan; and*
26 *(b) An insurer that offers group health benefit plan coverage shall not adjust*
27 *premium or contribution amounts for the group covered under the plan on*

1 ***the basis of genetic information.***
2 ***(3) (a) The commissioner, by administrative regulation, shall define essential***
3 ***health benefits.***
4 ***(b) Essential health benefits shall include at least the following general***
5 ***categories and the items and services covered within the categories:***
6 ***1. Ambulatory patient services;***
7 ***2. Emergency services;***
8 ***3. Hospitalization;***
9 ***4. Maternity and newborn care;***
10 ***5. Mental health and substance use disorder services, including***
11 ***behavioral health treatment;***
12 ***6. Prescription drugs;***
13 ***7. Rehabilitative and habilitative services and devices;***
14 ***8. Laboratory services;***
15 ***9. Preventive and wellness services and chronic disease management;***
16 ***and***
17 ***10. Pediatric services, including oral and vision care.***
18 ***(c) In defining essential health benefits under this subsection, the***
19 ***commissioner shall ensure that the essential health benefits are at least as***
20 ***comprehensive as the essential health benefits required of plans subject to***
21 ***the essential health benefits requirements of the Patient Protection and***
22 ***Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care***
23 ***and Education Reconciliation Act of 2010, Pub. L. No. 111-152, as in effect***
24 ***on January 1, 2021, and any federal rules and regulations adopted***
25 ***thereunder, as in effect on January 1, 2021.***
26 ***(4) In the case of a conflict between this section and any other law, this section shall***
27 ***control unless application of this section results in a reduction in coverage for***

1 ***any insured.***

2 ***(5) (a) Any health plan or health plan sponsor not otherwise required to comply***
3 ***with this section may elect to comply with the provisions of this section.***
4 ***(b) A health plan or health plan sponsor making an election under this***
5 ***subsection shall provide written notice to the commissioner, in the form and***
6 ***manner prescribed by the commissioner.***
7 ***(6) (a) This section shall become effective on the date determined under paragraph***
8 ***(c) of this subsection if any of the following laws, as in effect on January 1,***
9 ***2021, are repealed, amended so as to result in a reduction in consumer***
10 ***protections or coverage, or ruled by a court of competent jurisdiction to be***
11 ***no longer enforceable in Kentucky:***
12 ***1. 42 U.S.C. sec. 300gg-4, relating to:***
13 ***a. Eligibility rules based on health status-related factors;***
14 ***b. Premiums or contributions on the basis of any health status-***
15 ***related factor; or***
16 ***c. The adjustment of insurance premium or contribution amounts***
17 ***for groups on the basis of genetic information;***
18 ***2. 42 U.S.C. sec. 300gg-3, and all other provisions of 42 U.S.C. secs.***
19 ***300gg to 300gg-63, 42 U.S.C. sec. 300gg-91, and 42 U.S.C. sec. 300gg-***
20 ***92 relating to pre-existing condition exclusions;***
21 ***3. 42 U.S.C. sec. 300gg-11, relating to lifetime and annual limits on the***
22 ***dollar value of benefits; or***
23 ***4. 42 U.S.C. sec. 18022, relating to essential health benefit requirements.***
24 ***(b) 1. Within thirty (30) days of the earliest effective date of any event set***
25 ***forth in paragraph (a) of this subsection to occur, the commissioner***
26 ***shall deliver written notification of that event and the effective date of***
27 ***the event to the reviser of statutes.***

1 ***2. For purposes of this paragraph:***
2 ***a. The effective date of any repeal or amendment shall be the***
3 ***effective date of the repealing or amending legislation; and***
4 ***b. The effective date of any court ruling shall be the date upon***
5 ***which all appeals of that ruling have been exhausted or the time***
6 ***for appeal has elapsed.***
7 ***(c) This section shall become effective ten (10) days after the notification under***
8 ***paragraph (b) of this subsection is received by the reviser of statutes, who***
9 ***shall note the date of receipt of such notification in the official version of***
10 ***the Kentucky Revised Statutes.***
11 ***(7) This section shall apply to:***
12 ***(a) All health benefit plans issued or renewed on or after the effective date***
13 ***determined under subsection (6) of this section; and***
14 ***(b) Any health plans or health plan sponsors that elect, pursuant to subsection***
15 ***(5) of this section, to comply with the provisions of this section on or after***
16 ***the effective date determined under subsection (6) of this section.***
17 ➔Section 2. KRS 304.17A-096 is amended to read as follows:
18 (1) An insurer authorized to engage in the business of insurance in the Commonwealth
19 of Kentucky may offer one (1) or more basic health benefit plans in the individual,
20 small group, and employer-organized association markets. A basic health benefit
21 plan shall cover physician, pharmacy, home health, preventive, emergency, and
22 inpatient and outpatient hospital services in accordance with the requirements of
23 this subtitle. If vision or eye services are offered, these services may be provided by
24 an ophthalmologist or optometrist.
25 (2) An insurer that offers a basic health benefit plan shall be required to offer health
26 benefit plans as defined in KRS 304.17A-005(22).
27 (3) An insurer in the individual, small group, or employer-organized association

1 markets that offers a basic health benefit plan may offer a basic health benefit plan
2 that excludes from coverage any state-mandated health insurance benefit, except
3 that the basic health benefit plan shall include coverage for diabetes as provided in
4 KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic
5 benefits as provided in KRS 304.17A-171, mammograms as provided in KRS
6 304.17A-133, and those mandated benefits specified under federal law.
7 (4) Notwithstanding any other provisions of this section, mandated benefits excluded
8 from coverage shall not be deemed to include the payment, indemnity, or
9 reimbursement of specified health care providers for specific health care services.
10 ***(5) Upon the occurrence of, and beginning on, the effective date determined under***
11 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
12 ***subject to Section 1 of this Act.***
13 ➔Section 3. KRS 304.17A-097 is amended to read as follows:
14 An insurer that offers a basic health benefit plan shall disclose to all individuals, small
15 employer groups and employer-organized associations prior to the issuance of a policy
16 that the basic health benefit plan:
17 (1) Provides limited coverage;
18 (2) Includes federally mandated benefits; and
19 (3) Excludes state-mandated benefits, except for***:***
20 ***(a)*** Diabetes ***benefits*** as provided in KRS 304.17A-148***;***[,]
21 ***(b)*** Hospice ***benefits*** as provided in KRS 304.17A-250(6)***;***[, and]
22 ***(c)*** Chiropractic benefits as provided in KRS 304.17A-171***; and***
23 ***(d) Those benefits provided in Section 1 of this Act, upon the occurrence of,***
24 ***and beginning on, the effective date determined under subsection (6) of***
25 ***Section 1 of this Act***.
26 ➔Section 4. KRS 304.17A-200 is amended to read as follows:
27 (1) An insurer that offers health benefit plan coverage in the small group, large group,

1 or association market may not establish rules for eligibility of any individual to
2 enroll under the terms of the plan based on any of the following health status-related
3 factors in relation to the individual or the dependent of the individual:
4 (a) Health status;
5 (b) Medical condition, including both physical and mental illness;
6 (c) Claims experience;
7 (d) Receipt of health care;
8 (e) Medical history;
9 (f) Genetic information;
10 (g) Evidence of insurability, including conditions arising out of acts of domestic
11 violence; and
12 (h) Disability.
13 (2) An insurer that offers health benefit plan coverage in the small group, large group,
14 or association market shall not require any individual to pay a premium or
15 contribution which is greater than the premium or contribution for a similarly
16 situated individual enrolled in the plan on the basis of any health status-related
17 factor in relation to the individual or a dependent of the individual. Nothing in this
18 subsection shall prevent the insurer from establishing premium discounts or rebates
19 or modifying otherwise applicable copayments or deductibles in return for
20 adherence to programs of health promotion and disease prevention.
21 (3) Subject to subsections (4) to (7) of this section, each insurer that offers health
22 benefit plan coverage in the small groups market shall accept every small employer
23 that applies for coverage and shall accept for enrollment under this coverage every
24 individual eligible for the coverage who applies for enrollment during the period in
25 which the individual first becomes eligible to enroll under the terms of the group
26 health benefit plan.
27 (a) Notwithstanding any other provision of this subsection, the insurer may

1 establish group participation rules requiring a minimum number of
2 participants or beneficiaries that must be enrolled in relation to a specified
3 percentage or number of those eligible for enrollment.
4 (b) The terms and participation rules of the group health benefit plan shall be
5 uniformly applicable to small employers in the small group market.
6 (c) This subsection shall not apply to health benefit plan coverage offered by an
7 insurer if the coverage is made available in the small group market only
8 through one (1) or more bona fide associations.
9 (4) In the case of an insurer that offers health benefit plan coverage in the small group
10 market through a network plan, the insurer may:
11 (a) Limit the employers that may apply for coverage to those with individuals
12 who live, work, or reside in the service area of the network plan; and
13 (b) Within the service area of the network plan, deny coverage to employers if the
14 insurer has demonstrated to the commissioner that:
15 1. The network plan will not have the capacity to deliver services
16 adequately to enrollees of any additional groups because of its
17 obligations to existing group contract holders and enrollees; and
18 2. The insurer is applying this denial uniformly to all employers.
19 (5) An insurer, upon denying health benefit plan coverage in any service area in
20 accordance with subsection (4) of this section, shall not offer coverage in the small
21 group market within the service area for a period of one hundred eighty (180) days
22 after the date the coverage is denied.
23 (6) An insurer may deny health benefit plan coverage in the small group market if the
24 insurer has demonstrated to the commissioner that:
25 (a) The insurer does not have the financial reserves necessary to underwrite
26 additional coverage; and
27 (b) The insurer is applying this denial uniformly to all employers in the small

1 group market.
2 (7) An insurer, upon denying health benefit plan coverage in connection with group
3 health plans in accordance with subsection (6) of this section, shall not offer
4 coverage in the small group market for a period of one hundred eighty (180) days
5 after the date the coverage is denied or until the insurer has demonstrated to the
6 commissioner that the insurer has sufficient financial reserves to underwrite
7 additional coverage, whichever is later.
8 (8) A health benefit plan issued as an individual policy to individual employees or their
9 dependents through or with the permission of a small employer shall be issued on a
10 guaranteed-issue basis to all full-time employees and shall comply with the pre-
11 existing condition provisions of KRS 304.17A-220.
12 (9) (a) In connection with the offering of any health benefit plan to a small employer,
13 an insurer:
14 1. Shall make a reasonable disclosure to a small employer, as part of its
15 solicitation and sales materials, of the availability of information
16 described in paragraph (b) of this subsection; and
17 2. Upon request of a small employer, provide the information described in
18 paragraph (b) of this subsection.
19 (b) Subject to paragraph (c) of this subsection, with respect to an insurer offering
20 a health benefit plan to a small employer, information described in this
21 subsection is information concerning:
22 1. The provisions of the coverage concerning the insurer's right to change
23 premium rates and the factors that may affect changes in premium rates;
24 2. The provisions of the health benefit plan relating to renewability of
25 coverage;
26 3. The provisions of the health benefit plan relating to any preexisting
27 condition exclusion; and

1 4. The benefits and premiums available under all health benefit plans for
2 which the small employer is qualified.
3 (c) Information described in paragraph (b) of this subsection shall be provided to
4 a small employer in a manner determined to be understandable by the average
5 small employer and shall be sufficient to reasonably inform a small employer
6 of his or her rights and obligations under the health benefit plan.
7 (d) An insurer is not required under this section to disclose any information that is
8 proprietary and trade secret information under applicable law.
9 ***(10) Upon the occurrence of, and beginning on, the effective date determined under***
10 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
11 ***subject to Section 1 of this Act.***
12 ➔Section 5. KRS 304.17A-220 is amended to read as follows:
13 (1) ***(a) Except as provided in paragraph (b) of this subsection,*** all group health plans
14 and insurers offering group health insurance coverage in the Commonwealth
15 shall comply with the provisions of this section.
16 ***(b) Upon the occurrence of, and beginning on, the effective date determined***
17 ***under subsection (6) of Section 1 of this Act, the provisions of this section***
18 ***shall be subject to Section 1 of this Act.***
19 (2) Subject to subsection (8) of this section, a group health plan, and a health insurance
20 insurer offering group health insurance coverage, may, with respect to a participant
21 or beneficiary, impose a pre-existing condition exclusion only if:
22 (a) The exclusion relates to a condition, whether physical or mental, regardless of
23 the cause of the condition, for which medical advice, diagnosis, care, or
24 treatment was recommended or received within the six (6) month period
25 ending on the enrollment date. For purposes of this paragraph:
26 1. Medical advice, diagnosis, care, or treatment is taken into account only
27 if it is recommended by, or received from, an individual licensed or

1 similarly authorized to provide such services under state law and
2 operating within the scope of practice authorized by state law; and
3 2. The six (6) month period ending on the enrollment date begins on the
4 six (6) month anniversary date preceding the enrollment date;
5 (b) The exclusion extends for a period of not more than twelve (12) months, or
6 eighteen (18) months in the case of a late enrollee, after the enrollment date;
7 (c) 1. The period of any pre-existing condition exclusion that would otherwise
8 apply to an individual is reduced by the number of days of creditable
9 coverage the individual has as of the enrollment date, as counted under
10 subsection (3) of this section; and
11 2. Except for ineligible individuals who apply for coverage in the
12 individual market, the period of any pre-existing condition exclusion
13 that would otherwise apply to an individual may be reduced by the
14 number of days of creditable coverage the individual has as of the
15 effective date of coverage under the policy; and
16 (d) A written notice of the pre-existing condition exclusion is provided to
17 participants under the plan, and the insurer cannot impose a pre-existing
18 condition exclusion with respect to a participant or a dependent of the
19 participant until such notice is provided.
20 (3) In reducing the pre-existing condition exclusion period that applies to an individual,
21 the amount of creditable coverage is determined by counting all the days on which
22 the individual has one (1) or more types of creditable coverage. For purposes of
23 counting creditable coverage:
24 (a) If on a particular day the individual has creditable coverage from more than
25 one (1) source, all the creditable coverage on that day is counted as one (1)
26 day;
27 (b) Any days in a waiting period for coverage are not creditable coverage;

1 (c) Days of creditable coverage that occur before a significant break in coverage
2 are not required to be counted; and
3 (d) Days in a waiting period and days in an affiliation period are not taken into
4 account in determining whether a significant break in coverage has occurred.
5 (4) An insurer may determine the amount of creditable coverage in another manner than
6 established in subsection (3) of this section that is at least as favorable to the
7 individual as the method established in subsection (3) of this section.
8 (5) If an insurer receives creditable coverage information, the insurer shall make a
9 determination regarding the amount of the individual's creditable coverage and the
10 length of any pre-existing exclusion period that remains. A written notice of the
11 length of the pre-existing condition exclusion period that remains after offsetting for
12 prior creditable coverage shall be issued by the insurer. An insurer may not impose
13 any limit on the amount of time that an individual has to present a certificate or
14 evidence of creditable coverage.
15 (6) For purposes of this section:
16 (a) "Pre-existing condition exclusion" means, with respect to coverage, a
17 limitation or exclusion of benefits relating to a condition based on the fact that
18 the condition was present before the effective date of coverage, whether or not
19 any medical advice, diagnosis, care, or treatment was recommended or
20 received before that day. A pre-existing condition exclusion includes any
21 exclusion applicable to an individual as a result of information relating to an
22 individual's health status before the individual's effective date of coverage
23 under a health benefit plan;
24 (b) "Enrollment date" means, with respect to an individual covered under a group
25 health plan or health insurance coverage, the first day of coverage or, if there
26 is a waiting period, the first day of the waiting period. If an individual
27 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.

1 (7) (a) 1. Except as otherwise provided under subsection (3) of this section, for
2 purposes of applying subsection (2)(c) of this section, a group health
3 plan, and a health insurance insurer offering group health insurance
4 coverage, shall count a period of creditable coverage without regard to
5 the specific benefits covered during the period.
6 2. A group health plan, or a health insurance insurer offering group health
7 insurance coverage, may elect to apply subsection (2)(c) of this section
8 based on coverage of benefits within each of several classes or
9 categories of benefits specified in federal regulations. This election shall
10 be made on a uniform basis for all participants and beneficiaries. Under
11 this election, a group health plan or insurer shall count a period of
12 creditable coverage with respect to any class or category of benefits if
13 any level of benefits is covered within this class or category.
14 3. In the case of an election with respect to a group health plan under
15 subparagraph 2. of this paragraph, whether or not health insurance
16 coverage is provided in connection with the plan, the plan shall:
17 a. Prominently state in any disclosure statements concerning the plan,
18 and state to each enrollee at the time of enrollment under the plan,
19 that the plan has made this election; and
20 b. Include in these statements a description of the effect of this
21 election.
22 (b) Periods of creditable coverage with respect to an individual shall be
23 established through presentation of certifications described in subsection (9)
24 of this section or in such other manner as may be specified in administrative
25 regulations.
26 (8) (a) Subject to paragraph (e) of this subsection, a group health plan, and a health
27 insurance insurer offering group health insurance coverage, may not impose

1 any pre-existing condition exclusion on a child who, within thirty (30) days
2 after birth, is covered under any creditable coverage. If a child is enrolled in a
3 group health plan or other creditable coverage within thirty (30) days after
4 birth and subsequently enrolls in another group health plan without a
5 significant break in coverage, the other group health plan may not impose any
6 pre-existing condition exclusion on the child.
7 (b) Subject to paragraph (e) of this subsection, a group health plan, and a health
8 insurance insurer offering group health insurance coverage, may not impose
9 any pre-existing condition exclusion on a child who is adopted or placed for
10 adoption before attaining eighteen (18) years of age and who, within thirty
11 (30) days after the adoption or placement for adoption, is covered under any
12 creditable coverage. If a child is enrolled in a group health plan or other
13 creditable coverage within thirty (30) days after adoption or placement for
14 adoption and subsequently enrolls in another group health plan without a
15 significant break in coverage, the other group health plan may not impose any
16 pre-existing condition exclusion on the child. This shall not apply to coverage
17 before the date of the adoption or placement for adoption.
18 (c) A group health plan may not impose any pre-existing condition exclusion
19 relating to pregnancy.
20 (d) A group health plan may not impose a pre-existing condition exclusion
21 relating to a condition based solely on genetic information. If an individual is
22 diagnosed with a condition, even if the condition relates to genetic
23 information, the insurer may impose a pre-existing condition exclusion with
24 respect to the condition, subject to other requirements of this section.
25 (e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual
26 after the end of the first sixty-three (63) day period during all of which the
27 individual was not covered under any creditable coverage.

1 (9) (a) 1. A group health plan, and a health insurance insurer offering group health
2 insurance coverage, shall provide a certificate of creditable coverage as
3 described in subparagraph 2. of this subsection. A certificate of
4 creditable coverage shall be provided, without charge, for participants or
5 dependents who are or were covered under a group health plan upon the
6 occurrence of any of the following events:
7 a. At the time an individual ceases to be covered under a health
8 benefit plan or otherwise becomes eligible under a COBRA
9 continuation provision;
10 b. In the case of an individual becoming covered under a COBRA
11 continuation provision, at the time the individual ceases to be
12 covered under the COBRA continuation provision; and
13 c. On request on behalf of an individual made not later than twenty-
14 four (24) months after the date of cessation of the coverage
15 described in subdivision a. or b. of this subparagraph, whichever is
16 later.
17 The certificate of creditable coverage as described under subdivision a.
18 of this subparagraph may be provided, to the extent practicable, at a time
19 consistent with notices required under any applicable COBRA
20 continuation provision.
21 2. The certification described in this subparagraph is a written certification
22 of:
23 a. The period of creditable coverage of the individual under the
24 health benefit plan and the coverage, if any, under the COBRA
25 continuation provision; and
26 b. The waiting period, if any, and affiliation period, if applicable,
27 imposed with respect to the individual for any coverage under the

1 plan.
2 3. To the extent that medical care under a group health plan consists of
3 group health insurance coverage, the plan is deemed to have satisfied the
4 certification requirement under this paragraph if the health insurance
5 insurer offering the coverage provides for the certification in accordance
6 with this paragraph.
7 (b) In the case of an election described in subsection (7)(a)2. of this section by a
8 group health plan or health insurance insurer, if the plan or insurer enrolls an
9 individual for coverage under the plan and the individual provides a
10 certification of coverage of the individual under paragraph (a) of this
11 subsection:
12 1. Upon request of that plan or insurer, the entity that issued the
13 certification provided by the individual shall promptly disclose to the
14 requesting plan or insurer information on coverage of classes and
15 categories of health benefits available under the entity's plan or
16 coverage; and
17 2. The entity may charge the requesting plan or insurer for the reasonable
18 cost of disclosing this information.
19 (10) (a) A group health plan, and a health insurance insurer offering group health
20 insurance coverage in connection with a group health plan, shall permit an
21 employee who is eligible but not enrolled for coverage under the terms of the
22 plan, or a dependent of that employee if the dependent is eligible but not
23 enrolled for coverage under these terms, to enroll for coverage under the terms
24 of the plan if each of the following conditions is met:
25 1. The employee or dependent was covered under a group health plan or
26 had health insurance coverage at the time coverage was previously
27 offered to the employee or dependent;

1 2. The employee stated in writing at that time that coverage under a group
2 health plan or health insurance coverage was the reason for declining
3 enrollment, but only if the plan sponsor or insurer, if applicable, required
4 that statement at that time and provided the employee with notice of the
5 requirement, and the consequences of the requirement, at that time;
6 3. The employee's or dependent's coverage described in subparagraph 1. of
7 this paragraph:
8 a. Was under a COBRA continuation provision and the coverage
9 under that provision was exhausted; or
10 b. Was not under such a provision and either the coverage was
11 terminated as a result of loss of eligibility for the coverage,
12 including as a result of legal separation, divorce, cessation of
13 dependent status, such as obtaining the maximum age to be
14 eligible as a dependent child, death of the employee, termination of
15 employment, reduction in the number of hours of employment,
16 employer contributions toward the coverage were terminated, a
17 situation in which an individual incurs a claim that would meet or
18 exceed a lifetime limit on all benefits, or a situation in which a
19 plan no longer offers any benefits to the class of similarly situated
20 individuals that includes the individual; or
21 c. Was offered through a health maintenance organization or other
22 arrangement in the group market that does not provide benefits to
23 individuals who no longer reside, live, or work in a service area
24 and, loss of coverage in the group market occurred because an
25 individual no longer resides, lives, or works in the service area,
26 whether or not within the choice of the individual, and no other
27 benefit package is available to the individual; and

1 4. An insurer shall allow an employee and dependent a period of at least
2 thirty (30) days after an event described in this paragraph has occurred to
3 request enrollment for the employee or the employee's dependent.
4 Coverage shall begin no later than the first day of the first calendar
5 month beginning after the date the insurer receives the request for
6 special enrollment.
7 (b) A dependent of a current employee, including the employee's spouse, and the
8 employee each are eligible for enrollment in the group health plan subject to
9 plan eligibility rules conditioning dependent enrollment on enrollment of the
10 employee if the requirements of paragraph (a) of this subsection are satisfied.
11 (c) 1. If:
12 a. A group health plan makes coverage available with respect to a
13 dependent of an individual;
14 b. The individual is a participant under the plan, or has met any
15 waiting period applicable to becoming a participant under the plan
16 and is eligible to be enrolled under the plan but for a failure to
17 enroll during a previous enrollment period; and
18 c. A person becomes such a dependent of the individual through
19 marriage, birth, or adoption or placement for adoption;
20 the group health plan shall provide for a dependent special enrollment
21 period described in subparagraph 2. of this paragraph during which the
22 person or, if not otherwise enrolled, the individual, may be enrolled
23 under the plan as a dependent of the individual, and in the case of the
24 birth or adoption of a child, the spouse of the individual may be enrolled
25 as a dependent of the individual if the spouse is otherwise eligible for
26 coverage.
27 2. A dependent special enrollment period under this subparagraph shall be

1 a period of at least thirty (30) days and shall begin on the later of:
2 a. The date dependent coverage is made available; or
3 b. The date of the marriage, birth, or adoption or placement for
4 adoption, as the case may be, described in subparagraph 1.c. of this
5 paragraph.
6 3. If an individual seeks to enroll a dependent during the first thirty (30)
7 days of the dependent special enrollment period, the coverage of the
8 dependent shall become effective:
9 a. In the case of marriage, not later than the first day of the first
10 month beginning after the date the completed request for
11 enrollment is received;
12 b. In the case of a dependent's birth, as of the date of the birth; or
13 c. In the case of a dependent's adoption or placement for adoption,
14 the date of the adoption or placement for adoption.
15 (d) At or before the time an employee is initially offered the opportunity to enroll
16 in a group health plan, the employer shall provide the employee with a notice
17 of special enrollment rights.
18 (11) (a) In the case of a group health plan that offers medical care through health
19 insurance coverage offered by a health maintenance organization, the plan
20 may provide for an affiliation period with respect to coverage through the
21 organization only if:
22 1. No pre-existing condition exclusion is imposed with respect to coverage
23 through the organization;
24 2. The period is applied uniformly without regard to any health status-
25 related factors; and
26 3. The period does not exceed two (2) months, or three (3) months in the
27 case of a late enrollee.

1 (b) 1. For purposes of this section, the term "affiliation period" means a period
2 which, under the terms of the health insurance coverage offered by the
3 health maintenance organization, must expire before the health
4 insurance coverage becomes effective. The organization is not required
5 to provide health care services or benefits during this period and no
6 premium shall be charged to the participant or beneficiary for any
7 coverage during the period.
8 2. This period shall begin on the enrollment date.
9 3. An affiliation period under a plan shall run concurrently with any
10 waiting period under the plan.
11 (c) A health maintenance organization described in paragraph (a) of this
12 subsection may use alternative methods other than those described in that
13 paragraph to address adverse selection as approved by the commissioner.
14 ➔Section 6. KRS 304.17A-230 is amended to read as follows:
15 (1) A health insurer offering individual health benefit plan coverage in the individual
16 market in the Commonwealth shall not impose any pre-existing conditions
17 exclusions as to any eligible individual.
18 (2) Each health insurer offering individual health benefit plan coverage in the
19 individual market in the Commonwealth that chooses to impose a pre-existing
20 conditions exclusion on individuals who do not meet the definition of eligible
21 individual shall comply with the provisions of KRS 304.17A-220, which establishes
22 standards and requirements for pre-existing conditions exclusions for group health
23 plans, including crediting previous coverage, and certification of coverage.
24 Pregnancy may be considered to be a pre-existing condition.
25 (3) Genetic information shall not be treated as a pre-existing condition in the absence of
26 a diagnosis of the condition related to the information.
27 (4) ***Upon the occurrence of, and beginning on, the effective date determined under***

1 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
2 ***subject to Section 1 of this Act.***
3 ***(5)*** The ***commissioner***[Department of Insurance] shall promulgate administrative
4 regulations necessary to carry out the provisions of this section***,***[and] KRS
5 304.17A-220***, and Section 1 of this Act***.
6 ➔Section 7. KRS 304.17A-250 is amended to read as follows:
7 (1) The commissioner shall, by administrative regulations promulgated under KRS
8 Chapter 13A, define one (1) standard health benefit plan. After July 15, 2004,
9 insurers may offer the standard health benefit plan in the individual or small group
10 markets. Except as may be necessary to coordinate with changes in federal law, the
11 commissioner shall not alter, amend, or replace the standard health benefit plan
12 more frequently than annually.
13 (2) If offered, the standard health benefit plan may be available in at least one (1) of
14 these four (4) forms of coverage:
15 (a) A fee-for-service product type;
16 (b) A health maintenance organization type;
17 (c) A point-of-service type; and
18 (d) A preferred provider organization type.
19 (3) The standard health benefit plan shall be defined so that it meets the requirements of
20 KRS 304.17B-021 for inclusion in calculating assessments and refunds under
21 Kentucky Access.
22 (4) Any health insurer who offers the standard health benefit plan may offer the
23 standard health benefit plan in the individual or small group markets in each and
24 every form of coverage that the health insurer offers to sell.
25 (5) ***Except as provided in subsection (13) of this section,*** nothing in this section shall
26 be construed:
27 (a) To require a health insurer to offer a standard health benefit plan in a form of

1 coverage that the health insurer has not selected;
2 (b) To prohibit a health insurer from offering other health benefit plans in the
3 individual or small group markets in addition to the standard health benefit
4 plan; or
5 (c) To require that a standard health benefit plan have guaranteed issue,
6 renewability, or pre-existing condition exclusion rights or provisions that are
7 more generous to the applicant than the health insurer would be required to
8 provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-
9 240.
10 (6) All health benefit plans shall cover hospice care at least equal to the Medicare
11 benefits.
12 (7) All health benefit plans shall coordinate benefits with other health benefit plans in
13 accordance with the guidelines for coordination of benefits prescribed by the
14 commissioner as provided in KRS 304.18-085.
15 (8) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and
16 health service corporation, health maintenance organization, or provider-sponsored
17 health delivery network that issues or delivers an insurance policy in this state that
18 directs or gives any incentives to insureds to obtain health care services from certain
19 health care providers shall not imply or otherwise represent that a health care
20 provider is a participant in or an affiliate of an approved or selected provider
21 network unless the health care provider has agreed in writing to the representation
22 or there is a written contract between the health care provider and the insurer or an
23 agreement by the provider to abide by the terms for participation established by the
24 insurer. This requirement to have written contracts shall apply whenever an insurer
25 includes a health care provider as a part of a preferred provider network or
26 otherwise selects, lists, or approves certain health care providers for use by the
27 insurer's insureds. The obligation set forth in this section for an insurer to have

1 written contracts with providers selected for use by the insurer shall not apply to
2 emergency or out-of-area services.
3 (9) A self-insured plan may select any third party administrator licensed under KRS
4 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.
5 (10) Any health insurer that fails to issue a premium rate quote to an individual within
6 thirty (30) days of receiving a properly completed application request for the quote
7 shall be required to issue coverage to that individual and shall not impose any pre-
8 existing conditions exclusion on that individual with respect to the coverage. Each
9 health insurer offering individual health insurance coverage in the individual market
10 in the Commonwealth that refuses to issue a health benefit plan to an applicant or
11 insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or
12 for any reason, shall provide the individual with a denial letter within twenty (20)
13 working days of the request for coverage. The letter shall include the name and title
14 of the person making the decision, a statement setting forth the basis for refusing to
15 issue a policy, a description of Kentucky Access, and the telephone number for a
16 contact person who can provide additional information about Kentucky Access.
17 (11) If a standard health benefit plan covers services that the plan's insureds lawfully
18 obtain from health departments established under KRS Chapter 212, the health
19 insurer shall pay the plan's established rate for those services to the health
20 department.
21 (12) No individually insured person shall be required to replace an individual policy with
22 group coverage on becoming eligible for group coverage that is not provided by an
23 employer. In a situation where a person holding individual coverage is offered or
24 becomes eligible for group coverage not provided by an employer, the person
25 holding the individual coverage shall have the option of remaining individually
26 insured, as the policyholder may decide. This shall apply in any such situation that
27 may arise through an association, an affiliated group, the Kentucky state employee

1 health insurance plan, or any other entity.

2 ***(13) Upon the occurrence of, and beginning on, the effective date determined under***
3 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
4 ***subject to Section 1 of this Act.***

5 ➔Section 8. KRS 304.17A-430 is amended to read as follows:

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

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

17 (b) An individual entitled to benefits under the health benefit plan has been
18 diagnosed with a high-cost condition on or before the effective date of the
19 individual's coverage for coverage issued on a guarantee-issue basis after July
20 15, 1995;

21 (c) The health benefit plan imposes the maximum pre-existing condition
22 exclusion permitted under KRS 304.17A-200;

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

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

27 (2) Notwithstanding the provisions of subsection (1) of this section, if the total claims

1 paid for the high-cost condition under a program plan for any three (3) consecutive
2 years are less than the premiums paid under the program plan for those three (3)
3 consecutive years, then the following shall occur:
4 (a) The policy shall not be considered to be a program plan thereafter until the
5 first renewal of the policy after there are three (3) consecutive years in which
6 the total claims paid under the policy have exceeded the total premiums paid
7 for the policy and at the time of the renewal the policy also qualifies under
8 subsection (1) as a program plan; and
9 (b) Within the last six (6) months of the third year, the insurer shall provide each
10 person entitled to benefits under the policy who has a high-cost condition with
11 a written notice of insurability. The notice shall state that the recipient may be
12 able to purchase a health benefit plan other than a program plan and shall also
13 state that neither the notice nor the individual's actions to purchase a health
14 benefit plan other than a program plan shall affect the individual's eligibility
15 for plan coverage. The notice shall be valid for six (6) months.
16 (3) (a) There is established within the guaranteed acceptance program the alternative
17 underwriting mechanism that a participating insurer may elect to use. An
18 insurer that elects this mechanism shall use the underwriting criteria that the
19 insurer has used for the past twelve (12) months for purposes of the program
20 plan requirement in paragraph (b) of subsection (1) of this section for high-
21 risk individuals rather than using the criteria established in KRS 304.17A-005
22 and 304.17A-280 for high-cost conditions.
23 (b) An insurer that elects to use the alternative underwriting mechanism shall
24 make written application to the commissioner. Before the insurer may
25 implement the mechanism, the insurer shall obtain approval of the
26 commissioner. Annually thereafter, the insurer shall obtain the commissioner's
27 approval of the underwriting criteria of the insurer before the insurer may

1 continue to use the alternative underwriting mechanism.

2 ***(4) Upon the occurrence of, and beginning on, the effective date determined under***
3 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
4 ***subject to Section 1 of this Act.***

5 ➔Section 9. KRS 304.17B-015 is amended to read as follows:

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

9 (2) Any individual who is not an eligible individual who has been a resident of the
10 Commonwealth for at least twelve (12) months immediately preceding the
11 application for Kentucky Access coverage is eligible for coverage under Kentucky
12 Access if one (1) of the following conditions is met:

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

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

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

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

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

25 (a) 1. The individual has, or is eligible for, on the effective date of coverage
26 under Kentucky Access, substantially similar coverage under another
27 contract or policy, unless the individual was issued coverage from a

1 GAP participating insurer as a GAP qualified individual prior to January
2 1, 2001. A GAP qualified individual shall be automatically eligible for
3 coverage under Kentucky Access without regard to the requirements of
4 subsection (2) of this section; or
5 2. For individuals meeting the requirements of KRS 304.17A-005(11), the
6 individual has, or is eligible for, on the effective date of coverage under
7 Kentucky Access, coverage under a group health plan.
8 An individual who is ineligible for coverage pursuant to this paragraph shall
9 not preclude the individual's spouse or dependents from being eligible for
10 Kentucky Access coverage. As used in this paragraph, "eligible for" includes
11 any individual and an individual's spouse or dependent who was eligible for
12 coverage but waived that coverage. That individual and the individual's
13 spouse or dependent shall be ineligible for Kentucky Access coverage through
14 the period of waived coverage;
15 (b) The individual is eligible for coverage under Medicaid or Medicare;
16 (c) The individual previously terminated Kentucky Access coverage and twelve
17 (12) months have not elapsed since the coverage was terminated, unless the
18 individual demonstrates a good faith reason for the termination;
19 (d) Except for covered benefits paid under the standard health benefit plan as
20 specified in KRS 304.17B-019, Kentucky Access has paid two million dollars
21 ($2,000,000) in covered benefits per individual. The maximum limit under
22 this paragraph may be increased by the office;
23 (e) The individual is confined to a public institution or incarcerated in a federal,
24 state, or local penal institution or in the custody of federal, state, or local law
25 enforcement authorities, including work release programs; or
26 (f) The individual's premium, deductible, coinsurance, or copayment is partially
27 or entirely paid or reimbursed by an individual or entity other than the

1 individual or the individual's parent, grandparent, spouse, child, stepchild,
2 father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-
3 law, sister-in-law, grandchild, guardian, or court-appointed payor.
4 (5) The coverage of any person who ceases to meet the requirements of this section or
5 the requirements of any administrative regulation promulgated under this subtitle
6 may be terminated.
7 ***(6) Upon the occurrence of, and beginning on, the effective date determined under***
8 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
9 ***subject to Section 1 of this Act.***
10 ➔Section 10. KRS 304.17B-019 is amended to read as follows:
11 (1) Kentucky Access shall offer at least three (3) health benefit plans to enrollees,
12 which shall be similar to the health benefit plans currently being marketed to
13 individuals in the individual market.
14 (2) At least one (1) plan shall be offered in a traditional fee-for-service form. At least
15 one (1) plan may be offered in a managed-care form at such time as the Office of
16 Health Data and Analytics can establish an appropriate provider network in
17 available service areas.
18 (3) The office shall provide for utilization review and case management for all health
19 benefit plans issued under Kentucky Access.
20 (4) The office shall review and compare health benefit plans provided under Kentucky
21 Access to health benefit plans provided in the individual market. Based on the
22 review, the office may amend or replace the health benefit plans issued under
23 Kentucky Access.
24 (5) Individuals who apply and are determined eligible for health benefit plans issued
25 under Kentucky Access shall have coverage effective the first day of the month after
26 the application month.
27 (6) For eligible individuals, health benefit plans issued under Kentucky Access shall

1 not impose any pre-existing condition exclusions. In all other cases, a pre-existing
2 condition exclusion may be imposed in accordance with KRS 304.17A-230.
3 (7) Health benefit plans issued under Kentucky Access shall be guaranteed renewable
4 except as otherwise specified in KRS 304.17B-015 and KRS 304.17A-240.
5 (8) All health benefit plans issued under Kentucky Access shall provide that, upon the
6 death or divorce of the individual in whose name the contract was issued, every
7 other person covered in the contract may elect within sixty-three (63) days to
8 continue under the same or a different contract.
9 (9) Health benefit plans issued under Kentucky Access shall coordinate benefits with
10 other health benefit plans and be the payor of last resort.
11 (10) Health benefit plans issued under Kentucky Access shall pay covered benefits up to
12 a lifetime limit of two million dollars ($2,000,000) per covered individual. The
13 maximum limit under this subsection may be increased by the office.
14 ***(11) Upon the occurrence of, and beginning on, the effective date determined under***
15 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
16 ***subject to Section 1 of this Act.***
17 ➔Section 11. KRS 304.18-114 is amended to read as follows:
18 (1) As used in this section:
19 (a) "Conversion health insurance coverage" means a health benefit plan meeting
20 the requirements of this section and regulated in accordance with Subtitles 17
21 and 17A of this chapter;
22 (b) "Group policy" has the meaning provided in KRS 304.18-110; and
23 (c) "Medicare" has the meaning provided in KRS 304.18-110.
24 (2) An insurer providing group health insurance coverage shall offer a conversion
25 health insurance policy, by written notice, to any group member terminated under
26 the group policy for any reason. The insurer shall offer a conversion health
27 insurance policy substantially similar to the group policy. The former group

1 member shall meet the following conditions:
2 (a) The former group member had been a member of the group and covered under
3 any health insurance policy offered by the group for at least three (3) months;
4 (b) The former group member must make written application to the insurer for
5 conversion health insurance coverage not later than thirty-one (31) days after
6 notice pursuant to subsection (5) of this section; and
7 (c) The former group member must pay the monthly, quarterly, semiannual, or
8 annual premium, at the option of the applicant, to the insurer not later than
9 thirty-one (31) days after notice pursuant to subsection (5) of this section.
10 (3) An insurer shall offer the following terms of conversion health insurance coverage:
11 (a) Conversion health insurance coverage shall be available without evidence of
12 insurability and may contain a pre-existing condition limitation in accordance
13 with KRS 304.17A-230;
14 (b) The premium for conversion health insurance coverage shall be according to
15 the insurer's table of premium rates in effect on the latter of:
16 1. The effective date of the conversion policy; or
17 2. The date of application when the premium rate applies to the class of
18 risk to which the covered persons belong, to their ages, and to the form
19 and amount of insurance provided;
20 (c) The conversion health insurance policy shall cover the former group member
21 and eligible dependents covered by the group policy on the date coverage
22 under the group policy terminated.
23 (d) The effective date of the conversion health insurance policy shall be the date
24 of termination of coverage under the group policy; and
25 (e) The conversion health insurance policy shall provide benefits substantially
26 similar to those provided by the group policy, but not less than the minimum
27 standards set forth in KRS 304.18-120 and any administrative regulations

1 promulgated thereunder.
2 (4) Conversion health insurance coverage need not be granted in the following
3 situations:
4 (a) On the effective date of coverage, the applicant is or could be covered by
5 Medicare;
6 (b) On the effective date of coverage, the applicant is or could be covered by
7 another group coverage (insured or uninsured) or, the applicant is covered by
8 substantially similar benefits by another individual hospital, surgical, or
9 medical expenses insurance policy; or
10 (c) The issuance of conversion health insurance coverage would cause the
11 applicant to be overinsured according to the insurer's standards, taking into
12 account that the applicant is or could be covered by similar benefits pursuant
13 to or in accordance with the requirements of any statute and the individual
14 coverage described in paragraph (b) of this subsection.
15 (5) Notice of the right to conversion health insurance coverage shall be given as
16 follows:
17 (a) For group policies delivered, issued for delivery, or renewed after July 15,
18 2002, the insurer shall give written notice of the right to conversion health
19 insurance coverage to any former group member entitled to conversion
20 coverage under this section upon notice from the group policyholder that the
21 group member has terminated membership in the group, upon termination of
22 the former group member's continued group health insurance coverage
23 pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-005(7),
24 or upon termination of the group policy for any reason. The written notice
25 shall clearly explain the former group member's right to a conversion policy.
26 (b) The thirty-one (31) day period of subsection (2)(b) of this section shall not
27 begin to run until the notice required by this subsection is mailed or delivered

1 to the last known address of the former group member.
2 (c) If a former group member becomes entitled to obtain conversion health
3 insurance coverage, pursuant to this section, and the insurer fails to give the
4 former group member written notice of the right, pursuant to this subsection,
5 the insurer shall give written notice to the former group member as soon as
6 practicable after being notified of the insurer's failure to give written notice of
7 conversion rights to the former group member and such former group member
8 shall have an additional period within which to exercise his conversion rights.
9 The additional period shall expire sixty (60) days after written notice is
10 received from the insurer. Written notice delivered or mailed to the last known
11 address of the former group member shall constitute the giving of notice for
12 the purpose of this paragraph. If a former group member makes application
13 and pays the premium, for conversion health insurance coverage within the
14 additional period allowed by this paragraph, the effective date of conversion
15 health insurance coverage shall be the date of termination of group health
16 insurance coverage. However, nothing in this subsection shall require an
17 insurer to give notice or provide conversion coverage to a former group
18 member ninety (90) days after termination of the former group member's
19 group coverage.
20 ***(6) Upon the occurrence of, and beginning on, the effective date determined under***
21 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
22 ***subject to Section 1 of this Act.***
23 ➔Section 12. KRS 304.18-120 is amended to read as follows:
24 (1) A converted policy issued pursuant to the conversion privilege contained in a group
25 policy providing hospital or surgical expense insurance shall not impose a lifetime
26 maximum benefit of less than five hundred thousand dollars ($500,000).
27 (2) The commissioner by administrative regulation shall establish minimum benefits

1 for a converted policy issued pursuant to the conversion privilege contained in a
2 group health policy.
3 ***(3) Upon the occurrence of, and beginning on, the effective date determined under***
4 ***subsection (6) of Section 1 of this Act, the provisions of this section shall be***
5 ***subject to Section 1 of this Act.***
6 ➔Section 13. KRS 18A.225 (Effective April 1, 2021) is amended to read as
7 follows:
8 (1) (a) The term "employee" for purposes of this section means:
9 1. Any person, including an elected public official, who is regularly
10 employed by any department, office, board, agency, or branch of state
11 government; or by a public postsecondary educational institution; or by
12 any city, urban-county, charter county, county, or consolidated local
13 government, whose legislative body has opted to participate in the state-
14 sponsored health insurance program pursuant to KRS 79.080; and who
15 is either a contributing member to any one (1) of the retirement systems
16 administered by the state, including but not limited to the Kentucky
17 Retirement Systems, County Employees Retirement System, Kentucky
18 Teachers' Retirement System, the Legislators' Retirement Plan, or the
19 Judicial Retirement Plan; or is receiving a contractual contribution from
20 the state toward a retirement plan; or, in the case of a public
21 postsecondary education institution, is an individual participating in an
22 optional retirement plan authorized by KRS 161.567; or is eligible to
23 participate in a retirement plan established by an employer who ceases
24 participating in the Kentucky Employees Retirement System pursuant to
25 KRS 61.522 whose employees participated in the health insurance plans
26 administered by the Personnel Cabinet prior to the employer's effective
27 cessation date in the Kentucky Employees Retirement System;

1 2. Any certified or classified employee of a local board of education;
2 3. Any elected member of a local board of education;
3 4. Any person who is a present or future recipient of a retirement
4 allowance from the Kentucky Retirement Systems, County Employees
5 Retirement System, Kentucky Teachers' Retirement System, the
6 Legislators' Retirement Plan, the Judicial Retirement Plan, or the
7 Kentucky Community and Technical College System's optional
8 retirement plan authorized by KRS 161.567, except that a person who is
9 receiving a retirement allowance and who is age sixty-five (65) or older
10 shall not be included, with the exception of persons covered under KRS
11 61.702(4)(c), unless he or she is actively employed pursuant to
12 subparagraph 1. of this paragraph; and
13 5. Any eligible dependents and beneficiaries of participating employees
14 and retirees who are entitled to participate in the state-sponsored health
15 insurance program;
16 (b) The term "health benefit plan" for the purposes of this section means a health
17 benefit plan as defined in KRS 304.17A-005;
18 (c) The term "insurer" for the purposes of this section means an insurer as defined
19 in KRS 304.17A-005; and
20 (d) The term "managed care plan" for the purposes of this section means a
21 managed care plan as defined in KRS 304.17A-500.
22 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
23 recommendation of the secretary of the Personnel Cabinet, shall procure, in
24 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
25 from one (1) or more insurers authorized to do business in this state, a group
26 health benefit plan that may include but not be limited to health maintenance
27 organization (HMO), preferred provider organization (PPO), point of service

1 (POS), and exclusive provider organization (EPO) benefit plans encompassing
2 all or any class or classes of employees. With the exception of employers
3 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
4 employers of any class of employees or former employees shall enter into a
5 contract with the Personnel Cabinet prior to including that group in the state
6 health insurance group. The contracts shall include but not be limited to
7 designating the entity responsible for filing any federal forms, adoption of
8 policies required for proper plan administration, acceptance of the contractual
9 provisions with health insurance carriers or third-party administrators, and
10 adoption of the payment and reimbursement methods necessary for efficient
11 administration of the health insurance program. Health insurance coverage
12 provided to state employees under this section shall, at a minimum, contain
13 the same benefits as provided under Kentucky Kare Standard as of January 1,
14 1994, and shall include a mail-order drug option as provided in subsection
15 (13) of this section. All employees and other persons for whom the health care
16 coverage is provided or made available shall annually be given an option to
17 elect health care coverage through a self-funded plan offered by the
18 Commonwealth or, if a self-funded plan is not available, from a list of
19 coverage options determined by the competitive bid process under the
20 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
21 during annual open enrollment.
22 (b) The policy or policies shall be approved by the commissioner of insurance and
23 may contain the provisions the commissioner of insurance approves, whether
24 or not otherwise permitted by the insurance laws.
25 (c) Any carrier bidding to offer health care coverage to employees shall agree to
26 provide coverage to all members of the state group, including active
27 employees and retirees and their eligible covered dependents and

1 beneficiaries, within the county or counties specified in its bid. Except as
2 provided in subsection (20) of this section, any carrier bidding to offer health
3 care coverage to employees shall also agree to rate all employees as a single
4 entity, except for those retirees whose former employers insure their active
5 employees outside the state-sponsored health insurance program.
6 (d) Any carrier bidding to offer health care coverage to employees shall agree to
7 provide enrollment, claims, and utilization data to the Commonwealth in a
8 format specified by the Personnel Cabinet with the understanding that the data
9 shall be owned by the Commonwealth; to provide data in an electronic form
10 and within a time frame specified by the Personnel Cabinet; and to be subject
11 to penalties for noncompliance with data reporting requirements as specified
12 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
13 to protect the confidentiality of each individual employee; however,
14 confidentiality assertions shall not relieve a carrier from the requirement of
15 providing stipulated data to the Commonwealth.
16 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
17 for timely analysis of data received from carriers and, to the extent possible,
18 provide in the request-for-proposal specifics relating to data requirements,
19 electronic reporting, and penalties for noncompliance. The Commonwealth
20 shall own the enrollment, claims, and utilization data provided by each carrier
21 and shall develop methods to protect the confidentiality of the individual. The
22 Personnel Cabinet shall include in the October annual report submitted
23 pursuant to the provisions of KRS 18A.226 to the Governor, the General
24 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
25 financial stability of the program, which shall include but not be limited to
26 loss ratios, methods of risk adjustment, measurements of carrier quality of
27 service, prescription coverage and cost management, and statutorily required

1 mandates. If state self-insurance was available as a carrier option, the report
2 also shall provide a detailed financial analysis of the self-insurance fund
3 including but not limited to loss ratios, reserves, and reinsurance agreements.
4 (f) If any agency participating in the state-sponsored employee health insurance
5 program for its active employees terminates participation and there is a state
6 appropriation for the employer's contribution for active employees' health
7 insurance coverage, then neither the agency nor the employees shall receive
8 the state-funded contribution after termination from the state-sponsored
9 employee health insurance program.
10 (g) Any funds in flexible spending accounts that remain after all reimbursements
11 have been processed shall be transferred to the credit of the state-sponsored
12 health insurance plan's appropriation account.
13 (h) Each entity participating in the state-sponsored health insurance program shall
14 provide an amount at least equal to the state contribution rate for the employer
15 portion of the health insurance premium. For any participating entity that used
16 the state payroll system, the employer contribution amount shall be equal to
17 but not greater than the state contribution rate.
18 (3) The premiums may be paid by the policyholder:
19 (a) Wholly from funds contributed by the employee, by payroll deduction or
20 otherwise;
21 (b) Wholly from funds contributed by any department, board, agency, public
22 postsecondary education institution, or branch of state, city, urban-county,
23 charter county, county, or consolidated local government; or
24 (c) Partly from each, except that any premium due for health care coverage or
25 dental coverage, if any, in excess of the premium amount contributed by any
26 department, board, agency, postsecondary education institution, or branch of
27 state, city, urban-county, charter county, county, or consolidated local

1 government for any other health care coverage shall be paid by the employee.
2 (4) If an employee moves his or her place of residence or employment out of the service
3 area of an insurer offering a managed health care plan, under which he or she has
4 elected coverage, into either the service area of another managed health care plan or
5 into an area of the Commonwealth not within a managed health care plan service
6 area, the employee shall be given an option, at the time of the move or transfer, to
7 change his or her coverage to another health benefit plan.
8 (5) No payment of premium by any department, board, agency, public postsecondary
9 educational institution, or branch of state, city, urban-county, charter county,
10 county, or consolidated local government shall constitute compensation to an
11 insured employee for the purposes of any statute fixing or limiting the
12 compensation of such an employee. Any premium or other expense incurred by any
13 department, board, agency, public postsecondary educational institution, or branch
14 of state, city, urban-county, charter county, county, or consolidated local
15 government shall be considered a proper cost of administration.
16 (6) The policy or policies may contain the provisions with respect to the class or classes
17 of employees covered, amounts of insurance or coverage for designated classes or
18 groups of employees, policy options, terms of eligibility, and continuation of
19 insurance or coverage after retirement.
20 (7) Group rates under this section shall be made available to the disabled child of an
21 employee regardless of the child's age if the entire premium for the disabled child's
22 coverage is paid by the state employee. A child shall be considered disabled if he or
23 she has been determined to be eligible for federal Social Security disability benefits.
24 (8) The health care contract or contracts for employees shall be entered into for a period
25 of not less than one (1) year.
26 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
27 State Health Insurance Subscribers to advise the secretary or the secretary's designee

1 regarding the state-sponsored health insurance program for employees. The
2 secretary shall appoint, from a list of names submitted by appointing authorities,
3 members representing school districts from each of the seven (7) Supreme Court
4 districts, members representing state government from each of the seven (7)
5 Supreme Court districts, two (2) members representing retirees under age sixty-five
6 (65), one (1) member representing local health departments, two (2) members
7 representing the Kentucky Teachers' Retirement System, and three (3) members at
8 large. The secretary shall also appoint two (2) members from a list of five (5) names
9 submitted by the Kentucky Education Association, two (2) members from a list of
10 five (5) names submitted by the largest state employee organization of nonschool
11 state employees, two (2) members from a list of five (5) names submitted by the
12 Kentucky Association of Counties, two (2) members from a list of five (5) names
13 submitted by the Kentucky League of Cities, and two (2) members from a list of
14 names consisting of five (5) names submitted by each state employee organization
15 that has two thousand (2,000) or more members on state payroll deduction. The
16 advisory committee shall be appointed in January of each year and shall meet
17 quarterly.
18 (10) Notwithstanding any other provision of law to the contrary, the policy or policies
19 provided to employees pursuant to this section shall not provide coverage for
20 obtaining or performing an abortion, nor shall any state funds be used for the
21 purpose of obtaining or performing an abortion on behalf of employees or their
22 dependents.
23 (11) Interruption of an established treatment regime with maintenance drugs shall be
24 grounds for an insured to appeal a formulary change through the established appeal
25 procedures approved by the Department of Insurance, if the physician supervising
26 the treatment certifies that the change is not in the best interests of the patient.
27 (12) Any employee who is eligible for and elects to participate in the state health

1 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any
2 one (1) of the state-sponsored retirement systems shall not be eligible to receive the
3 state health insurance contribution toward health care coverage as a result of any
4 other employment for which there is a public employer contribution. This does not
5 preclude a retiree and an active employee spouse from using both contributions to
6 the extent needed for purchase of one (1) state sponsored health insurance policy for
7 that plan year.
8 (13) (a) The policies of health insurance coverage procured under subsection (2) of
9 this section shall include a mail-order drug option for maintenance drugs for
10 state employees. Maintenance drugs may be dispensed by mail order in
11 accordance with Kentucky law.
12 (b) A health insurer shall not discriminate against any retail pharmacy located
13 within the geographic coverage area of the health benefit plan and that meets
14 the terms and conditions for participation established by the insurer, including
15 price, dispensing fee, and copay requirements of a mail-order option. The
16 retail pharmacy shall not be required to dispense by mail.
17 (c) The mail-order option shall not permit the dispensing of a controlled
18 substance classified in Schedule II.
19 (14) The policy or policies provided to state employees or their dependents pursuant to
20 this section shall provide coverage for obtaining a hearing aid and acquiring hearing
21 aid-related services for insured individuals under eighteen (18) years of age, subject
22 to a cap of one thousand four hundred dollars ($1,400) every thirty-six (36) months
23 pursuant to KRS 304.17A-132.
24 (15) Any policy provided to state employees or their dependents pursuant to this section
25 shall provide coverage for the diagnosis and treatment of autism spectrum disorders
26 consistent with KRS 304.17A-142.
27 (16) Any policy provided to state employees or their dependents pursuant to this section

1 shall provide coverage for obtaining amino acid-based elemental formula pursuant
2 to KRS 304.17A-258.
3 (17) If a state employee's residence and place of employment are in the same county, and
4 if the hospital located within that county does not offer surgical services, intensive
5 care services, obstetrical services, level II neonatal services, diagnostic cardiac
6 catheterization services, and magnetic resonance imaging services, the employee
7 may select a plan available in a contiguous county that does provide those services,
8 and the state contribution for the plan shall be the amount available in the county
9 where the plan selected is located.
10 (18) If a state employee's residence and place of employment are each located in counties
11 in which the hospitals do not offer surgical services, intensive care services,
12 obstetrical services, level II neonatal services, diagnostic cardiac catheterization
13 services, and magnetic resonance imaging services, the employee may select a plan
14 available in a county contiguous to the county of residence that does provide those
15 services, and the state contribution for the plan shall be the amount available in the
16 county where the plan selected is located.
17 (19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and
18 in the best interests of the state group to allow any carrier bidding to offer health
19 care coverage under this section to submit bids that may vary county by county or
20 by larger geographic areas.
21 (20) Notwithstanding any other provision of this section, the bid for proposals for health
22 insurance coverage for calendar year 2004 shall include a bid scenario that reflects
23 the statewide rating structure provided in calendar year 2003 and a bid scenario that
24 allows for a regional rating structure that allows carriers to submit bids that may
25 vary by region for a given product offering as described in this subsection:
26 (a) The regional rating bid scenario shall not include a request for bid on a
27 statewide option;

1 (b) The Personnel Cabinet shall divide the state into geographical regions which
2 shall be the same as the partnership regions designated by the Department for
3 Medicaid Services for purposes of the Kentucky Health Care Partnership
4 Program established pursuant to 907 KAR 1:705;
5 (c) The request for proposal shall require a carrier's bid to include every county
6 within the region or regions for which the bid is submitted and include but not
7 be restricted to a preferred provider organization (PPO) option;
8 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
9 carrier all of the counties included in its bid within the region. If the Personnel
10 Cabinet deems the bids submitted in accordance with this subsection to be in
11 the best interests of state employees in a region, the cabinet may award the
12 contract for that region to no more than two (2) carriers; and
13 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
14 other requirements or criteria in the request for proposal.
15 (21) Any fully insured health benefit plan or self-insured plan issued or renewed on or
16 after July 12, 2006, to public employees pursuant to this section which provides
17 coverage for services rendered by a physician or osteopath duly licensed under KRS
18 Chapter 311 that are within the scope of practice of an optometrist duly licensed
19 under the provisions of KRS Chapter 320 shall provide the same payment of
20 coverage to optometrists as allowed for those services rendered by physicians or
21 osteopaths.
22 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or
23 after ***the effective date of this Act***~~[July 12, 2006]~~, to public employees pursuant to
24 this section shall comply with***:***
25 ***(a) Section 1 of this Act, upon the occurrence of, and beginning on, the***
26 ***effective date determined under subsection (6) of Section 1 of this Act;***
27 ***(b)*** ~~[the provisions of]~~KRS 304.17A-270 and 304.17A-525***;***

(c) KRS 304.17A-600 to 304.17A-633;

(d) KRS 205.593;

(e) KRS 304.17A-700 to 304.17A-730;

(f) KRS 304.14-135;

(g) KRS 304.17A-580 and 304.17A-641;

(h) KRS 304.99-123;

(i) KRS 304.17A-138; and

(j) Administrative regulations promulgated pursuant to statutes listed in this subsection.

~~[(23) Any fully insured health benefit plan or self -insured plan issued or renewed on or after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641 pertaining to emergency medical care, KRS 304.99-123, and any administrative regulations promulgated thereunder.~~

~~(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 1, 2019, to public employees pursuant to this section shall comply with KRS 304.17A-138.]~~