Insurance Legislation Adopted by the 2008 Kentucky General Assembly (Regular Session)

COMMONWEALTH OF KENTUCKY

DEPARTMENT OF INSURANCE

Frankfort, Kentucky

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INSURANCE LEGISLATION ADOPTED BY THE

2008 KENTUCKY GENERAL ASSEMBLY (REGULAR SESSION)

June 24, 2008

THIS BULLETIN IS FOR INFORMATION PURPOSES ONLY. IT DOES NOT AMEND OR INTERPRET PROVISIONS OF THE KENTUCKY REVISED STATUTES OR THE KENTUCKY ADMINISTRATIVE REGULATIONS. THE COMPLETE AND ACCURATE TEXT OF THE LAW CAN BE SECURED WHEN THE 2008 ACTS OF THE KENTUCKY GENERAL ASSEMBLY ARE PUBLISHED IN THE SUMMER OF 2008. UNLESS OTHERWISE NOTED, THE EFFECTIVE DATE OF THE LEGISLATION IS JULY 15, 2008.

*(Bills as enacted are available on the LRC Web site at **www.lrc.ky.gov/record/08rs/record.htm**)*

Senate Bill 93 – Operation of golf carts on a public roadway

This bill allows a local government to adopt an ordinance to authorize and regulate the operation of a golf cart on a public roadway that lies within five miles of an entrance to a golf course. The ordinance must require that a golf cart operated on a designated public roadway:

- Be issued a permit;
- Display a sticker or permit that identifies that the golf cart is allowed to be operated on specific roadways;
- Be inspected by a certified inspector designated by a county sheriff and certified through the Department of Vehicle Regulation.

A person may operate a golf cart on a designated public roadway if:

- The posted speed limit is 35 mph or less;
- The operator does not cross a roadway at an intersection where the roadway being crossed has a posted speed limit of more than 35 mph;
- The operator has a valid operator's license in his or her possession;
- The golf cart is being operated between sunrise and sunset; and

- The golf cart displays a slow-moving vehicle emblem.

The golf cart being operated on a public roadway must be insured in compliance with KRS 304.39-080 and the proof of insurance must be inside the golf cart at all times. However, the golf cart is not considered to be a motor vehicle and is exempt from:

- Title requirements;
- Vehicle registration requirements; and
- Emissions compliance certificates.

Contact: *Property and Casualty Division*

(502) 564-6046

Senate Bill 96 – Colorectal Cancer Screenings

This bill creates a new statute within KRS 304, Subtitle 17A to require health benefit plans issued or renewed on or after January 1, 2009 to:

- Provide coverage for all colorectal cancer examinations and laboratory tests specified in the current American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals. The covered individual shall be:
  - 50 years of age or older; or
  - Less than 50 years of age and at high risk for colorectal cancer according to the guidelines of the American Cancer Society.
- Prohibit the application of a separate deductible or separate coinsurance for this coverage.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

Senate Bill 149 – Metabolic Disorders

With regard to insurance, this bill repeals provisions in KRS 304.17A-139 related to coverage for treatment of inherited metabolic diseases and creates a new statute within KRS 304, Subtitle 17A to require health benefit plans that provide prescription drug coverage to:

- Provide coverage for therapeutic food, formulas, supplements and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions if the food is obtained under the direction of a physician;

- Allows coverage to be subject to a cap of $25,000 for each plan year for therapeutic food, formulas, and supplements; and a cap of $4,000 for each plan year for low-protein modified foods. The caps are subject to annual inflation adjustments based on the consumer price index.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

Senate Bill 167 – Debt cancellation agreements

This bill amends KRS 190.100 to:

- Define a "debt cancellation agreement" as a written provision in a retail installment contract, or separate addendum thereto, which provides for cancellation of all or part of an obligation of the buyer or obligor upon the occurrence of a specified event; and
- Clarify that a debt cancellation agreement is not insurance.

Contact: *Property and Casualty Division*
(502) 564-6046

House Bill 84 – Group Life Insurance

This bill amends various statutes within KRS 304 Subtitle 16 related to group life insurance primarily to adopt the provisions of the NAIC Model Law. Specifically, the bill makes the following changes:

Section 1 – Employee Groups (KRS 304.16-030)

- Removes the exception that premium may be paid entirely by the insureds if the amount of insurance does not exceed $2,000 on the life of any employee;
- Removes the 75 percent participation requirement by eligible employees; and
- Requires eligible employees to reject coverage in writing if they choose not to be insured.

Section 2 – Debtor Groups (KRS 304.16-040)

- Allows the group policy to be issued to an affiliated company of the creditor;
- Removes the limitation that a group member shall be one whose indebtedness is repayable either in installments or in one sum within 18 months from the initial date of debt, and allows the group members to be from any class of indebtedness;
- Amends the definitions of "debtor" to include borrowers of money or purchaser or lessees of goods, services or property for which payment is arranged through a credit transaction;

- Removes the 75 percent participation requirement by eligible debtors and the requirement that the group have at least 100 new entrants yearly; and
- Limits the amount of life insurance written to the credit limit for policies written in connection with open-end credit having a limit exceeding $10,000.

Section 3 – Labor Union Groups (KRS 304.16-050)

- Removes the 75 percent participation requirement by eligible members; and
- Requires eligible members to reject coverage in writing if they choose not to be insured.

Section 4 – Trustee Groups (KRS 304.16-060)

- Removes the participation requirements that previously set forth various minimum percentages for eligible members and minimum numbers of covered lives;
- Requires eligible persons to reject coverage in writing if they choose not to be insured.

Section 5 – Public Employee Groups (KRS 304.16-070)

- Removes the 75 percent participation requirement by eligible members.

Section 6 – Association Groups (KRS 304.16-080)

- Clarifies that a group life insurance policy may be issued to a trust maintained for the benefit of members of one or more associations that meet the following requirements:
    - The association has, at the outset, a minimum of one member
    - The association has been in active existence for at least two (2) years
    - The constitution or by-laws provide for an annual meeting, the collection of dues from members, and voting privileges and representation by members on the governing board and committees;
- Removes the requirement that at least twenty-five (25) members of the association are insured;
- Requires the policy to provide coverage for members of the association or employees of members for the benefit of persons other than the employee's employer;
- Requires the premium to be paid from funds contributed by the association, employer members or covered persons.

Section 7 – Dependent's Coverage (KRS 304.16-085)

- Removes the limitation prohibiting dependent coverage from being in excess of 50 percent of the employees' or members' insurance.

Section 8 – Credit Union Groups (KRS 304.16-090)

- Allows for a group life insurance policy to be issued to a trust designated by two or more credit unions;
- Requires the premium for the policy to be paid by the policyholder from the credit union's funds;
- Removes the 75 percent participation requirement by eligible members;
- Removes the requirement that at least twenty-five (25) members of the credit union are insured; and
- Removes the limitation that the amount of insurance under the policy cannot exceed the amount of the total shares and deposits of the member.

Section 9 – Beneficiary (KRS 304.16-170)

- Increases from $500 to $2,000 the maximum amount that could be reimbursed to any person other than the beneficiary for payment of funeral or other expenses related to the last illness or death of the insured.

Section 10 – Conversion on Termination of Eligibility (KRS 304.16-190)

- Allows the conversion privilege to be made available to a:
    - Surviving dependent upon the termination of coverage under the group policy due to the death of the employee or member; and
    - Dependent upon the termination of coverage under the group policy because the dependent ceases to be a qualified family member under the group policy.

Section 11 – Conversion on Termination of Policy (KRS 304.16-200)

- Allows an insured dependent who has been insured under a group policy for at least five years to be entitled to conversion privileges.

Contact: *Life Insurance Division*

(502) 564-6071

House Bill 179 – Paid-Up Life Insurance Policies

This bill requires insurers to provide notice to the Office of Insurance within thirty (30) days of completion of all policy payments. Utilizing the reported data, the Office of Insurance is required to respond to policyholder inquiries regarding their policy in the event of loss or destruction of the policy or acquisition or merger of the insurer.

Contact: *Life Insurance Division*

(502) 564-6071

House Bill 204 – Transportation of Persons

This bill amends KRS 281.605 to exempt from the provisions of KRS Chapter 281, Motor Carriers, the transportation of persons who are sixty (60) years old or visually impaired if the motor vehicles are being used by or on behalf of a non-profit organization. However, the bill requires privately owned motor vehicles used on behalf of a non-profit organization to comply with the liability insurance coverage requirements established in KRS 304.39-110, even though the vehicles are otherwise exempt under this statute.

Contact: *Property and Casualty Division*

(502) 564-6046

House Bill 259 – Long-Term Care Partnership Program

This bill provides the enabling legislation to establish a Long-Term Care Partnership Insurance Program in Kentucky. The program is established as a partnership between the Department for Medicaid Services and the Office of Insurance to:

- Provide incentives for an individual to insure against the cost of providing for his or her long-term care needs;
- Increase utilization of long-term care insurance policies;
- Assist in alleviating the financial burden of Kentucky's Medicaid program by encouraging the use of private insurance; and
- Provide a mechanism for individuals to qualify for Medicaid services for costs of long-term care without exhausting all of their assets and resources.

The bill requires the Department for Medicaid Services to:

- Submit an amendment to the State Medicaid Plan to permit the establishment of a Kentucky Long-Term Care Partnership Insurance Program by October 30, 2008.
- Establish the Kentucky Long-Term Care Partnership Insurance Program in conjunction with the Office of Insurance.

The bill requires the Office of Insurance to:

- Approve long-term care partnership policies pursuant to KRS 304.14-120.
- Develop uniform training materials in consultation with the Department for Medicaid Services for agents who sell long-term care insurance policies. (Insurers will be responsible for ensuring that any agent who sells a long-term care partnership policy can demonstrate an understanding of long-term care partnership insurance and how it relates to other public and private coverage of long-term care expenses.)
- Promulgate an administrative regulation to implement the Kentucky Long-Term Care Partnership Insurance Program within sixty (60) days of notice of approval of the amendment to the State Medicaid Plan.

- In conjunction with the Department for Medicaid Services, report to the Interim Joint Committee on Banking and Insurance and the Interim Joint Committee on Health and Welfare on the status of the program no later than September 30 of each year.
- In coordination with the Cabinet for Health and Family Services, promulgate a regulation to establish the content of a disclosure statement required to be provided to a prospective applicant outlining the requirements and benefits of a partnership policy.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

Agent Licensing Division

(502) 564-6004

House Bill 316 – Basic Health Benefit Plan Coverage of Mammograms

This bill amends KRS 304.17A-096 to require a basic health benefit plan to insurance coverage for mammograms, as provided in KRS 304.17A-133.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

House Bill 334 – Insurance Producer Modernization

Section 1 of this bill amends KRS 304.9-350 to:

- Clarify that an individual or business entity dually licensed as both a consultant and an agent cannot act as an agent with respect to a specific insurance transaction for which they have a written consulting contract. The prohibition against acting as an agent for that specific risk is in effect during the term of the written consulting contract and for the period of 12 months after the expiration of the contract but no less than 24 months from the inception of the contract. This prohibition also applies to an agent who has a financial or business ownership interest or affiliations with the consultant.
- Specify the information that must be included in a consultant's contract and requires a consulting contract to be retained for a minimum of five (5) years after its expiration.

- Allow an agent who also holds a formal financial planning certification or designation to receive a fee for services under that designation and commission for the sale of life insurance or annuities if specific disclosures are provided to the party to be charged.

A consultant or agent found to be in violation of this section is subject to a fine in the amount of the consultant's or agent's fees or commissions associated with the sale of the product which is the subject of the violation in addition to suspension or revocation of the consultant's or agent's license.

Section 2 of this bill creates a new statute in KRS Chapter 304, Subtitle 11 to allow an agent to receive compensation from the insurer or the client for the placement of insurance and services rendered to the client. The compensation arrangement must be specified in a written disclosure agreement.

For purposes of this section, the term, "client" is specifically defined to mean the following:

1. For health insurance, group life insurance and ancillary employee benefits, the person meets or exceeds one of the following:

    - Total assets of the business of at least $25,000,000; or
    - Total sales or revenue of at least $25,000,000.

    The person also meets or exceeds one of the following:

    - Total number of eligible employees of at least 100; or
    - Annual health and employee benefits premiums of at least $500,000.

2. A person whose health benefit plan is procured through an employer-organized association as defined in KRS 304.17A-005.

3. For property insurance and casualty insurance, the person meets or exceeds one of the following:

    - Total assets of the business of at least $25,000,000; or
    - Total sales or revenue of at least $25,000,000.

The person also meets or exceeds one of the following:

- Total number of eligible employees of at least 100; or
- Annual property and casualty policy premiums of at least $400,000.

4. A person purchasing an unbundled insurance program with:

- Fixed costs exceeding $100,000; or
- With a deductible relative to any one line of coverage of at least $100,000.

The provisions of this section do not apply to personal lines of insurance issued for personal or family protection.

Section 3 of this bill amends KRS 304.12-100 to exempt from Kentucky's unfair discrimination, rebating and illegal inducement laws, the furnishing of information, advice, programs or services that are intended to reduce the future cost of insurance of the policyholder or the probability of loss, assist in the efficient administration and management of a policyholder's insurance program, or assist the policyholder in complying with any state or federal law. Examples provided with the bill include, but are not limited to, the following:

- Software to administer an insured's employee benefits or risk management programs;
- Employee wellness programs;
- Risk management services;
- Loss control services; or
- Workers' compensation analysis forecasting.

Contact: *Agent Licensing Division*

(502) 564-6004

House Bill 348 – Life Settlements

HB 348 amends Kentucky's Viatical Settlements law, KRS 304.15-700 through 304.15-725, the definitions found in KRS 304.15-020, and creates new statutes within the Insurance Code to:

- Adopt many provisions of the NCOIL Life Settlements Model Law;

- Regulate “stranger-originated life insurance” (STOLI);
- Update terminology to reference “life settlements” rather than “viatical settlements”;
- Provide additional protection against trust-initiated STOLI and other schemes with regard to insurable interest.

Specifically, HB 348 includes the following amendments:

Section 1 – Definitions (KRS 304.15-020)

- Includes new definitions for “advertisement,” “financing transaction,” “life expectancy,” “premium finance loan,” “purchaser,” “settled policy,” and “stranger-originated life insurance (STOLI).

Section 2 – General Rules (KRS 304.15-700)

- Prohibits an insurer that is the subject of a life settlement contract from being responsible for any act or omission of a broker, purchaser or provider unless the insurer receives compensation for the placement of the life settlement contract from the broker, purchaser or provider.
- Prohibits an insurer from requiring the owner, insured, provider or broker to sign any form as a condition of responding to a request for verification of coverage or in connection with the settlement of a policy that has not been approved by the Office of Insurance for use in connection with life settlement contracts.

Section 3 – Advertisements (new statute)

- Requires advertisements used by life settlement brokers or life settlement providers to comply with the Insurance Code.
- Further requires advertisements to be accurate, truthful and not misleading.
- Prohibits a person or a trust from advertising the purchase of a life insurance policy for the purpose of settling the policy and from using the words “free” or “no cost” in the advertising material.

Section 4 – Disclosures (KRS 304.15-710)

- Requires a provider to provide specific disclosures in a separate written document that is signed by the owner and the provider.
- Requires those disclosures to be conspicuously displayed in a life settlement contract or a separate document furnished to the owner.
- Adds the following information to the listing of required disclosures:
    - The date by which the funds will be available to the owner and the transmitter of the funds;
    - That a consumer guide shall be delivered to owners with each application;
    - That applications and life settlement contracts contain a fraud statement;
    - That a broker represents exclusively the owner, and not the insurer or the provider, and owes a fiduciary duty to the owner including a duty to act according to the owner's instructions and in the best interests of the owner; and
    - The fact that a change in ownership could, in the future, limit the insured's ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life.
- Requires the broker to provide to the owner and the provider the following information no later than the date the life settlement contract is signed by all parties:
    - The name, business address and telephone number of the broker;
    - A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed life settlement contract;
    - The name of each broker who receives compensation and the amount of compensation received by the broker;
    - A complete reconciliation of the gross offer or bid by the provider to the net proceeds or value to be received by the owner.

<u>Section 5 – Inquiries and Disclosures by Insurers About Premium Financing (new statute)</u>

Permits an insurer to:

- Inquire in the insurance application whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing;
- Make disclosures to the applicant and insured that if the person entered into a loan agreement with the policy as collateral and if the policy does change ownership in satisfaction of the loan, that change in ownership could lead to a stranger owning an interest in the insured's life and could limit the insured's ability to purchase future insurance on the insured's life;
- Require certification from the applicant or insured that he or she has not entered into an agreement for the future sale of the policy, that the loan arrangement is sufficient to pay premiums and costs, and that the borrower has an insurable interest in the insured.

<u>Section 6 – Life Settlement Contracts (KRS 304.15-715)</u>

- Prohibits an insurer from unreasonably delaying the change of ownership or beneficiary with any lawful life settlement contract;
- Requires the provider to notify the insurer within twenty (20) days after an owner executes a life settlement contract;

- Requires a fee paid to a broker for services provided to an owner pertaining to a life settlement contract to be computed as a percentage of the offer obtained rather than the face value of the policy;
- Requires the broker to disclose to the owner anything of value paid or given to a broker which relates to a life settlement contract.

Section 7 – Exceptions to Prohibition of Settling a Life Insurance Contract Within 2 Years After Issuance (KRS 304.15-716)

Adds the following exceptions to the prohibition of entering into a life settlement within two (2) years of issuance of a life insurance policy:

- Death of the owner's spouse;
- Divorce;
- Retirement;
- Physical or mental disability of owner;
- Bankruptcy of the owner.

Section 8 – Unlawful Acts (KRS 304.15-717)

This section adds the following acts to those declared to be unlawful with respect to a life settlement transaction:

- Engaging in any transaction, practice or course of business if the person knows or reasonably should have known that the intent was to avoid the notice requirements in the life settlement statutes;
- Issuing, soliciting, marketing or otherwise promoting the purchase of a life insurance policy for the purpose of or with a primary emphasis on settling the policy;
- Entering into a life settlement contract on a policy that was the subject of a premium finance agreement;
- For an insurer, broker or provider, making any statement or representation in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy;
- Knowingly entering into a life settlement contract with an owner if, in connection with the life settlement contract, anything of value will be paid to a broker or provider under common control or controlled by the provider, broker, or financing entity or related provider trust;
- If an insurer,
    - engages in or permits any discrimination between individuals of the same class, policy amount and equal expectation of life in the rates charged for any life insurance policy or annuity contract based upon an individual's having entered into a life settlement contract or being insured under a settled policy;
    - makes false or misleading statements as to the business of life settlements or financing premiums due for a policy or to any owner or insured for the purpose of inducing or tending to induce the owner or insured not to enter into a life settlement contract;

- engages in any transaction, act, practice or course of business or deals which restricts, limits or impairs in any way the lawful transfer of ownership, change of beneficiary or assignment of a policy.

Section 9 – Reporting Requirements (new statute)

This section requires each provider to file with the Executive Director on or before March 1 of each year an annual statement. The format and content of the statement will be prescribed by the Executive Director in an administrative regulation and must include the names of the insurance companies whose policies have been settled.

Section 10 – Insurable Interest (new statute)

Provides that it is a violation of insurable interest for any person or entity without insurable interest to

- Provide or arrange for the funding ultimately used to pay premiums on a life insurance policy;
- At policy inception, have an arrangement for a person or entity to have an ownership interest in the majority of the death benefit of that life insurance policy.

Sections 11 – 27 – Conforming Amendments

Numerous statutes throughout the Insurance Code are amended to conform to the provisions of this bill. The primary amendments address the use of the term "life settlement" rather than "viatical settlement."

Contact: *Life Insurance Division*

(502) 564-6071

House Bill 406 Part XII – ICARE

Part XII of HB 406 continues the Insurance Coverage Affordability and Relief to Small Employers (ICARE) Program, a four-year pilot program for small employer groups of two to 25 employees, including those who are members of an employer-organized association. All insurers that issue health benefit plans to small groups are deemed to be ICARE participating insurers.

The legislation creates two (2) categories of eligibility:

1. Employers that have not provided health insurance in the last twelve (12) months; and

2. Employers with at least one (1) member of the group identified as having a defined high cost condition.

In both eligibility categories, the average salary of the group, excluding the owner, can not exceed 300 percent of the Federal Poverty Level. Further, the employer must pay 50 percent of the premium cost and meet the insurer's participation requirements.

The ICARE program provides the following premium subsidy to eligible employers for qualified health benefit plans:

- For employers who were previously uninsured
  - Premium subsidy of $40 per employee per month (subsidy decreases by $10 per year over the four years of the pilot program)
  - Qualified health benefit plans include a consumer-driven health benefit plan (HRA or HSA) or a basic health benefit plan.

- For employer groups with a high cost individual
  - Premium subsidy of $60 per employee per month (subsidy decreases by $15 per year over the four years of the pilot program)
  - Qualified health plans include a consumer-driven health benefit plan (HRA or HSA), a basic health benefit plan or a traditional health benefit plan.

A Health Risk Assessment is required to be completed for each employee participating in ICARE to encourage prevention, early treatment and promotion of healthy behaviors. Participating insurers are required to offer a premium rate that includes a healthy lifestyle discount.

In addition to the ICARE Program, Part XII of HB 406 includes the following provisions:

- **Medicaid related**
  - **Health Insurance Premium Payment (HIPP) program disclosure**
    - Requires insurers to disclose to employers the availability of the HIPP program. The HIPP program allows the State to purchase employer sponsored commercial coverage on behalf of Medicaid eligible employees when it is financially advantageous for the state.
  - **Medicaid coordination of benefits**
    - Requires insurers to provide eligibility information to Medicaid;
    - Ensures that Medicaid is the payor of last resort; and
    - Assesses a penalty for failing to provide information.
- **Interstate Reciprocal Health Benefit Plan Compact**
  - Provides enabling language to explore the creation of an interstate compact with neighboring states for health benefit plan product and rate approval.
- **Transparency**
  - Amends existing statute in order to promote timely, electronically accessible information available to consumers related to health care cost, quality and outcomes;
  - Provides better direction and better defined access as to what information is made available to consumers via the Cabinet for Health and Family Services, regarding:
    - Cost;
    - Quality; and
    - Outcomes for hospitals and ambulatory surgery centers;
  - Requires use of nationally endorsed quality indicators for purposes of making comparative information available between hospitals in both urban and rural areas;

- Enhances the data reporting requirements of hospitals and ambulatory care centers; and
- Sets forth requirements for standards for protection of information (HIPAA).

- **Prompt pay**
  - Amends the interest rate for payment of late claims to 12 percent annually for claims paid between one (1) and 30 days late and 14 percent annually for claims over 31 days late; and
  - Updates requirement for acknowledgement to allow reasonableness for determination of claims status.

Contact: *ICARE Program*

(502) 573-1029

House Bill 440 – Provider Credentialing; Dependent Coverage

Section 1 – Definitions (new statute in KRS 304, Subtitle 17A)

This section defines the following terms related to provider credentialing:

- Applicant
- Enrollee
- Managed care plan
- Nonparticipating provider

Section 2 – Credentialing and Payment (new statute in KRS 304, Subtitle 17A)

This section requires an insurer issuing a managed care plan to notify an applicant of its credentialing decision within ninety (90) days of a properly submitted application containing all information required

by the most recent version of the Council for Affordable Healthcare credentialing form. Insurers are permitted to require information beyond the information required in the credentialing form in order to make a determination regarding the application.

Following credentialing and upon the applicant's signing of a contract with the managed care plan, the insurer shall pay the applicant for services rendered during the credentialing process as a participating provider. Applicants who are denied credentialing shall be reimbursed as a non-participating provider if the enrollee's plan provides for out-of-network benefits.

Section 3 – Payment Information (new statute in KRS 304, Subtitle 17A

Section 3 requires insurers issuing managed care plans:

- To provide, upon request of a health care provider, payment or fee schedules or other information to enable the provider to determine the manner and amount of payments for services prior to final execution of the contract or renewal of the contract if the payment or fee schedule has changed. The information given to the provider must include a description of process and factors that may affect the actual payment, including copayments, coinsurance, deductibles, risk sharing arrangements and liability of third parties. This information may be made available electronically or through a Web site.
- To provide, upon request of a health care provider, an explanation of the methodology used to determine actual payment for procedures frequently performed by the provider if the actual payment for the procedures cannot b ascertained from the fee schedule or other information. The methodology disclosure shall include:
  - The name of any relative value system
  - The version, edition, or publication date of the relative value system; and
  - Any applicable conversion or geographic factor.

  This information may be made available electronically or through a Web site.

Providers receiving payment of fee schedules are required to maintain the confidentiality of this proprietary information.

Section 4 – Material Changes to Provider Agreements (new statute in KRS 304, Subtitle 17A)

With regard to a material change to an existing provider agreement,

- An insurer is required to provide ninety (90) days written notice of the material change to a participating provider. The notice must include a description of the material change and a statement that the participating provider has the option to withdraw from the agreement prior to the material change becoming effective.
- If a participating provider opts to withdraw from an agreement after receipt of a notice of a material change, the provider is required to send written notice of withdrawal to the insurers no later than forty-five (45) days prior to the effective date of the material change.

Sections 5 and 6 – Conforming Amendments to KRS 304.17A-254, 304.17A-527

Sections 4 and 5 incorporate the requirements of this bill into existing statutes within the Insurance Code.

Section 7 – Unfair Claims Settlement Practices (KRS 304.12-230)

This section makes it an unfair claims settlement practice for an insurer to fail to comply with:

- The provisions of KRS 304.17A-714 when collecting claim overpayments from providers;
- The provisions of KRS 304.17A-708 on resolution of payment errors and retroactive denial of claims.

Section 8 – Dependent Coverage (new statute in KRS 304, Subtitle 17A)

This section requires group health benefit plans which provide dependent benefits to offer the master policyholder two options to purchase coverage for an unmarried dependent child:

- Coverage until age 19 and coverage to unmarried children from 19 – 25 years of age who are full-time students;
- Coverage until age 25.

The offer must include a disclaimer that selecting either option may have tax implications.

Section 9 – Dependent Coverage (KRS 304.17-310)

This section amends an existing statute to require insurers offering family expense health insurance to offer the applicant the option to purchase coverage for unmarried dependent children until age 25.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

House Bill 524 – Local Government Premium Tax

Section 1 - Definitions

This section defines the terms, "local government," "risk location system or program" and "tax period."

Section 2 – Administrative Procedures for Amended Returns, Assessments by Local Governments and Refund Requests from Policyholders

Section 2 of this bill creates a new statute in KRS 91A to establish the sole and exclusive method for the filing of amended returns and requests or assessments by any insurance company, local government or policyholder for nonpayment, underpayment or overpayment of local government premium taxes. Specifically, these sections require the following:

Statute of Limitations

- The statute of limitations for the 2009 tax year and forward is changed from five years to two years.
- The two-year period begins on the due date of the annual reconciliation, March 31 of each year.
- Exceptions to this statute of limitation are established for fraudulent returns and for litigation pending on the effective date of the Act, July 15, 2008.

Process for Filing an Amended Premium Tax Return by Insurance Companies

- Requires a refund or credit by an insurance company to be made by mailing an amended return and supporting documentation to the local government to which the tax was paid.
- Specifies that a complete refund request includes the amended return and supporting documentation including:
    - Location of the risk by street address or another appropriate identifier of the physical location;
    - Amount of the erroneous payment;
    - Premium charged;
    - Amount of tax actually collected;

    - Type of risk insured;
    - Period the policy was in force during the taxable year.
- For tax periods beginning in 2010, local governments may assess a 10 percent penalty on refund requests if the insurance company can not produce proof that it used a risk location system verified by the Office of Insurance.
- If a local government fails to accept the complete amended return or refuses to issue the refund request within 90 days of receipt, the insurance company may appeal to the Office of Insurance within 30 days. An appeal must be sent by certified mail to the Office of Insurance.
- The Office of Insurance must issue a final order that the request for refund or credit is or is not warranted in whole or in part within 60 days of receipt of the completed application. One 30 day extension may be granted for issuance of the order.
- An insurance company is prohibited from applying a credit to taxes imposed without a written agreement from the local government or an order from the Office of Insurance.

Process for Filing Refund Requests by Policyholders

- Requires a request for a refund or a credit for an overpayment by a policyholder to be made by mailing the request to the insurance company to which the tax was paid.
- Specifies that the request must include the following:
    - Address of the location of the risk insured;
    - Amount of the overpayment of the tax that was erroneously paid;
    - Dates of coverage;
    - Amount of tax that was paid;
    - Type of risk insured.
- If an insurance company fails to make payment or grant credit within 90 days of receipt of the request, the policyholder may appeal to the Office of Insurance within 30 days. An appeal must be sent by certified mail to the Office of Insurance.
- The Office of Insurance must issue a final order that the request for refund or credit is or is not warranted in whole or in part within 60 days of receipt of the completed application. One 30 day extension may be granted for issuance of the order.

Process for Assessments of Additional Tax by a Local Government

- Requires a local government to request the Office of Insurance to conduct an audit if it believes that a tax has not been paid or has been underpaid.
- Allows the local government to assess the insurance company based upon the finding of the audit.
- Specifies that a notice of assessment include the following:
    - Total amount of payment due;
    - The geographic area affected;
    - The applicable license fee or tax rate.
- In response to a notice of assessment, requires the insurance company to pay the assessment in full or file an appeal of the audit and the assessment within 90 days of receipt. An appeal must be sent by certified mail to the Office of Insurance.

- The Office of Insurance must issue a final order on the findings of the audit and a determination that the assessment is or is not warranted in whole or in part within 60 days of receipt of the completed application. One 30 day extension may be granted for issuance of the order.
- Either the insurance company or the local government may appeal the order of the Office of Insurance within 60 days.
- If the insurer fails to respond to the notice of assessment within the statutory 90-day time frame, the local government may file the notice of assessment with the Office of Insurance within 30 days. Within 30 days of receipt of a notice of assessment, the Office of Insurance shall issue an order to the insurance company to pay the assessment and additional penalties.
- Any refund or credit received by an insurance company that passed the tax on to the policyholder and that is not owed to another local government is required to be refunded to the policyholder.
    - The refund must be paid by the insurance company within 90 days of receipt and must include any collection fee retained by the insurance company for administration of the tax.
    - Beginning in 2010, the refund must also include a penalty fee of 10 percent of the total amount of the refund if the insurance company is unable to produce proof of the use of a risk location system verified by the Office of Insurance.

Confidentiality

- Information on specific policies and policyholders provided to local governments shall be considered confidential and propriety information and not disclosed or subject to the Open Records Act.
- Proprietary information provided to a local government is required to be destroyed in an irreversible, secure and confidential manner once it is no longer needed for compliance purposes.
- Violations of this section shall result in civil and criminal penalties for improper disclosure.

<u>Section 3 – Verification of Risk Location Systems</u>

- This section requires the Office of Insurance to establish criteria for the verification of risk location systems and programs by January 1, 2009. The criteria must require risk location systems to utilize the municipal and county boundary data available from the Commonwealth Office of Technology and based upon filings with the Secretary of State.
- Vendors or insurance companies seeking verification of software are required to file an application and a $2,500 application fee with the Office of Insurance.
- The Office of Insurance is required to test the risk location system to determine whether it meets the established criteria for verification.

<u>Section 4 – Local Premium Tax Advisory Council</u>

- Requires the establishment of an eight-member council, chaired by the Executive Director of the Office of Insurance, to provide advice and expertise on the imposition, administration and collection of local government premium taxes.

- Membership includes:
    - Two city government representatives
    - Two county government representatives
    - One independent insurance agent
    - One representative of a domestic insurance company
    - One representative of a foreign insurance company
    - One representative of an insurance trade association
- The duties of the council include:
    - Making recommendations on needed legislative changes
    - Providing comments on needed regulatory reforms
    - Providing information and assistance to insurance companies and local governments regarding procedures and practices related to compliance
    - Reviewing the criteria for verification of risk location systems or programs and making recommendations for updating and improving the criteria

Sections 5 and 6 – Conforming Amendments

- These sections provide conforming amendments to KRS 91A.080 and KRS 304.10-180.

Section 7 – Notice Requirements

- Beginning December 31, 2008, requires insurance companies to include the amount of the local government tax charged and the name of the taxing jurisdiction on renewal certificates or billings
- Before December 31, 2008, requires insurance companies to send a one-time notification to current policyholders regarding their rights under the legislation. The notice can be sent separately or as an additional item with statements, billings or other notices.
- Requires the Office of Insurance to promulgate a regulation setting forth the text of the notice.
- Requires insurance companies to provide a policyholder with information on the procedural requirements for requesting a refund or a credit within 30 days of a request.

Contact: *Consumer Protection & Education Division*

(502) 564-6034

House Bill 551 – Pharmacy Claims Payment

This bill creates a new statute within KRS 304.17A-700 to 304.17A-730, Kentucky's prompt payment law, to require

- Any contract between an insurer and a pharmacy benefits manager that requires clean claims to be submitted electronically to provide for electronic payment of claims if electronic payment is requested by the provider;
- Any contract between an insurer and a participating provider that requires clean claims to be submitted electronically to provide for electronic payment of claims if electronic payment is requested by the provider.

This bill applies to contracts entered into, amended, extended or renewed on or after January 1, 2009.

Contact: *Health Insurance Policy and Managed Care Division*

(502) 564-6088

House Bill 577 – Military Sales Practices

This bill provides the enabling language to allow the Office of Insurance to adopt the National Association of Insurance Commissioners (NAIC) Military Sale Practices Model Regulation in accordance with the federal Military Personnel Financial Services Protection Act.

Contact: *Life Insurance Division*

(502) 564-6071

House Bill 590 – Insurance Examinations; Advertisements for Free Insurance

Model Examination Law

This bill adopts the National Association of Insurance Commissioners (NAIC) Model Examination Law. Specifically, this bill provides for the following:

- Adds a new definition of "examination workpaper";
- Requires the executive director to consider the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent

certified public accountants and other criteria set forth in the NAIC Examiner's Handbook when scheduling and determining the scope of examinations;

- Allows the executive director to examine any person that the executive director determines is necessary and material to the examination of the insurer.
- Allows the executive director to accept the examination of another state if:
    - The insurance department was accredited by the NAIC at the time of the examination; or
    - The exam was performed under the supervision of an accredited insurance department or with the participation of examiners who are employed by an accredited insurance department.
- Requires the examiner to observe the guidelines and procedures set forth in the NAIC Examiner's Handbook, but allows the executive director to employ other guidelines that he or she deems appropriate.
- Prohibits an examiner from being appointed if he or she has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in the person being examined.
- Grants immunity to examiners for acts arising out of their duties or employment. However, excludes from immunity damage, loss, injury or liability caused by intentional or willful and wanton misconduct of an examiner, assistant or contractor.
- Allows the executive director to terminate or suspend an examination to pursue other legal or regulatory action.
- The executive director may use and, if appropriate, make public any final or preliminary examination report workpapers or other information discovered during the course of the examination in furtherance of any legal or regulatory action. Nothing shall be binding upon the court in making determinations about relevancy and admissibility in any civil action pertaining to the documents.
- Deems examination workpapers to be confidential except that the executive director may disclose an examination workpaper, preliminary examination report, or examination results to:
    - Another department of insurance;
    - The NAIC;
    - Law enforcement officials;
    - A state or federal agency

  if the receiving the information agrees to hold the information confidential.

Prohibition Against Free Insurance

This bill also creates a new statute in KRS 304, Subtitle 12, to prohibit the advertising, offering or providing of free insurance for damage, loss or theft as an inducement to the purchase, sale or rental of consumer goods or services directly or indirectly connected with consumer goods.

Contact: *Financial Standards & Examination Division*

(502) 564-6082

Legal Division

(502) 564-6032

House Bill 758 – Workers' Compensation Self-Insured Groups

This bill was agency legislation for the Office of Insurance to provide necessary housekeeping changes identified through implementation of SB 86 from the 2005 legislative session. Specifically, the changes include:

- Amend KRS 304.50-020 to make provisions of subtitle applicable to a "bona-fide trade association" rather than an "association";

- Amend KRS 304.50-035 to clarify that the exemption from the minimum surplus requirement applies to self-insured groups operating under a plan approved by the Executive Director of the Office of Insurance or a remedial action plan approved by the Executive Director of the Office of Workers' Claims prior to August 3, 2004;

- Amend KRS 304.50-050 to **c**alculate the amount of the required security deposit based on the reserve requirement established in the most recent audited financial statement (rather than a certified statement);

- Require approval of a bank or trust company that a workers' compensation self-insured group proposes to use for security deposit and sets qualifications for approval;

- Amend KRS 304.50-055:

    - To allow equity securities that are actively traded on any registered national securities exchange, not just New York or NASDAQ. Current language would *exclude* investments such as Fannie Mae and Freddie Mac, which we consider to be high quality investments. Therefore, the proposal is to add language that would include "other national securities exchanges";

- Correct a drafting error to ensure that US Government bonds, US Treasury notes and bills, other US Government guaranteed obligations, as well as 'A' rated KY tax exempt obligations would qualify as eligible securities;

- Remove the requirement that certificates of deposit must be issued by a commercial bank in the Commonwealth, and allows certificates of deposit issued by any duly chartered commercial bank;

- Require investments in Corporate Bonds do not exceed 25 percent (was 15 percent) of the total market value of investment portfolio, allowing more corporate bonds in time of declining, or unstable, stock market;

- Require 50 percent (was 75 percent) of entire investment to be in cash and cash equivalents, allowing a more diversified portfolio with the potential of earning higher investment yields;

- Hold 5 percent (was 15 percent) in cash and cash equivalents that mature in one year or less, enabling the funds to earn higher yields;

- Amend KRS 304.50-060 to:

  - Clarify that proof of specific excess insurance coverage is to be filed within 10 days before the expiration of the self-insurance year;

  - Require proof of aggregate excess insurance to be filed within 10 days before the expiration of the self-insurance year unless aggregate insurance is waived;

  - Amend the statute to require the annual filing be made 120 days after the year-end;

  - Require a self-insured group to make available the statement of financial condition upon request of a group member.

- Amend KRS 304.50-115 to apply filing fees to both rate and form filings;

- Amend KRS 304.50-120 to incorporate a standard for waiving the purchase of aggregate excess insurance for self-insured groups if the group's fund balance is 30 percent or more of earned premiums.

Contact: *Financial Standards & Examination Division*

(502) 564-6082

Other Legislation of Interest

House Bill 44 – Data Collection

This bill requires the Secretary of the Cabinet for Health and Family Services to publish and make available information on the cost and quality of health care services. Providers are required to report data on specified medical conditions on a quarterly basis. Aggregate data will be made available to the public. Persons requesting use of the data are required to abide by a public-use data agreement and by HIPAA privacy rules. Additionally, the Cabinet for Health and Family Services shall include cost and quality information on health care services on its Web site.

The bill also amends KRS 205.623 to require health insurers and administrators to provide policy, coverage and claims information for policyholders and dependents to the Department for Medicaid Services in their prescribed electronic file format. Information reported under this requirement will be held confidential. Failure of an insurer or administrator to provide this information will be considered an unfair or deceptive trade practice.

House Bill 676 – Classic Motor Vehicle Project Titles

This bill amends KRS 186A.510 to define a "classic motor vehicle project" as a motor vehicle that is:

- **At least twenty-five (25) years old;**
- **Not in road worthy condition; and**
- **Either currently in this state and not titled or being brought into this state with a regular title from another state that does not denote it as "salvage," "junk," "rebuilt," or any similar designation.**

The bill creates a new statute in KRS Chapter 186A.500 to 186A550 to permit the owner of a motor vehicle that meets the definition of a classic motor vehicle project certificate of title. Vehicles bearing this title may be operated upon the highways of the Commonwealth when they are en route to or from an inspection by the certified inspector prior to obtaining a certificate of title after having been restored.

/s/ John Burkholder June 24, 2008

John Burkholder Date

Acting Commissioner

Kentucky Department of Insurance