

**COMMONWEALTH OF KENTUCKY
OFFICE OF INSURANCE
Frankfort, Kentucky**

BULLETIN 2006 - 03

**INSURANCE LEGISLATION ADOPTED BY THE
2006 KENTUCKY GENERAL ASSEMBLY (REGULAR SESSION)**

JUNE 9, 2006

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 2006 ACTS OF THE KENTUCKY GENERAL ASSEMBLY ARE PUBLISHED IN THE SUMMER OF 2006. UNLESS OTHERWISE NOTED, THE EFFECTIVE DATE OF THE LEGISLATION IS JULY 12, 2006.

(Bills as enacted are available on the LRC Web site at www.lrc.ky.gov/record/06rs/record.htm)

Senate Bill 98 – Administrative Regulations

This bill amends KRS 13A.250 to require that a cost analysis be prepared by the promulgating agency for any administrative regulation that relates to any aspect of state or local government. The cost analysis is required to include the projected cost or cost savings to state agencies and local governments. Any affected agency is permitted to submit comments on the administrative regulation to the promulgating agency.

*Contact: Executive Director's Office
(502) 564-6026*

Senate Bill 107 – Viatical Settlement Brokers

This bill amends KRS 304.15-700 to allow an individual who is licensed as a life insurance agent and who has held that license for at least twelve (12) months, to act as a viatical settlement broker, without being licensed. The bill requires a licensed life insurance agent acting as a viatical settlement broker to:

- notify the Executive Director, through a form prescribed by administrative regulation, within thirty (30) days of first operating as a viatical settlement broker; and
- obtain and file with the Office of Insurance evidence of financial responsibility covering the legal liability of the agent related to the transaction of viatical settlements in the amount of \$20,000 per occurrence and \$100,000 in the aggregate.

This bill also lowers the minimum financial responsibility limits for licensed viatical settlement brokers from \$500,000 per occurrence and \$1,500,000 in the aggregate to \$20,000 per occurrence and \$100,000 in the aggregate.

An informational packet and forms are located at <http://doi.ppr.ky.gov>

*Contact: Agent Licensing Division
KOAgentlicensingmail@ky.gov*

(502) 564-6004

Senate Bill 133 – Military Affairs

This bill amends KRS 304.13-063 to require an insurer to include in its schedule of rates or rating plan an actuarially sound premium reduction for an insured of any age who is a member of the US Armed Forces that completes a defensive driving course provided by the Armed Forces. This legislation becomes effective January 1, 2007.

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

House Bill 112 – Interstate Insurance Product Regulation Compact

This bill creates a new subtitle of KRS Chapter 304 to adopt the enabling legislation that allows Kentucky to join the National Association of Insurance Commissioners' (NAIC) Interstate Insurance Product Regulation Compact. The compact is a mechanism for developing uniform national product standards for life insurance, annuities, disability income insurance and long-term care insurance products. It will create a single point to file products for regulatory review and approval. In the event of approval, an insurer would then be able to sell its products in multiple states without separate filings in each state.

Contact: *Life Insurance Division*
(502) 564-6071

House Bill 131 – Vision and Dental Plans for State Employees; State Employee Group Health Plan; Reimbursement for Optometrists

This bill includes provisions impacting health benefit plans for state employees and the private insurance market.

Vision and Dental Plans for State Employees

This legislation creates a new statute in KRS 18A that requires the procurement of a comprehensive dental insurance plan or plans and a comprehensive vision insurance plan or plans for state employees on a voluntary, payroll deduction basis. The employee would be responsible for the entire premium cost. The legislation defines a comprehensive dental insurance plan as including preventive and diagnostic care. Specified services may also be included. The legislation specifies that the vision plan may include diagnostic services, preventive care and eye wear.

These comprehensive vision and dental insurance plans may be offered by a licensed insurer, limited health service organization or non-profit medical-surgical, dental or health service corporation. The plans are subject to the any willing provider requirements of KRS 304.17A-270.

Further, the procurement of these vision and dental plans does not prevent vision and dental benefits from being included in the state employee health plan.

The insurance policies providing these benefits must be approved by the Office of Insurance. The information distributed by insurers to state employees regarding the vision and dental plans must be approved by the Personnel Cabinet.

The legislation also requires the procurement of a dental discount plan and a vision discount plan or plans for state employees on a voluntary, payroll deduction basis. The employee would be responsible for the entire premium cost.

State Employee Health Plan

The legislation requires any fully insured or self-insured plans issued to state employees to comply with specific provisions of the Insurance Code related to any willing provider; standards for provider participation; utilization review, internal appeals and external review; prompt payment of claims; uniform health insurance claim forms; and emergency medical care.

The legislation creates a new statute in KRS 18A to require a self-insured plan offered to state employee to include a mail order drug option for maintenance drugs. The plan may not discriminate against any retail pharmacy that is able to meet the terms and conditions for participation in the mail order drug option.

Reimbursement for Optometrists

Any health benefit plan, including plans issued by Kentucky Access, any limited health service benefit plan, and any fully insured or self-insured plan for state employees, issued or renewed on or after July 12, 2006, which provides coverage for services by a physician or osteopath must provide the same payment of coverage to optometrists performing those services, if those services are within the scope of practice of an optometrist.

*Contact: Health Insurance Policy and Managed Care Division
(502) 564-6088*

House Bill 142 – Pre-need Funeral Contracts

Section 3 of this bill amends KRS 304.12-240 to prohibit an insurer from paying life insurance or annuity benefits used to fund pre-need funeral contracts until the agent has provided the insurer with a death certificate or provisional death certificate. In this statute, “agent” is defined as the person receiving payments on the pre-need funeral contract.

*Contact: Life Insurance Division
(502) 564-6071*

House Bill 181 – Exceptions Policy or Override Policy for Prescription Drug Benefits

This bill creates a new section of KRS 304 Subtitle 17A to require any health benefit plan that covers prescriptions drugs to include an exceptions policy or override policy. The exceptions or override policy must provide coverage for a refill prior to the expiration of the insured’s supply of the prescription drug. An insurer is permitted to limit the number of refills to no more than three (3) refills in a 90-day period. This section is not applicable to controlled substances.

An insurer is required to provide notice of the exceptions or override policy to participating pharmacies, pharmacy benefits managers and insureds.

*Contact: Health Insurance Policy and Managed Care Division
(502) 564-6088*

House Bill 238 – Refund of Unearned Premium

This bill creates new statutes within KRS 304 Subtitles 14 and 17 to require insurers to promptly refund any unearned premium in the event that a policy is canceled. The refund requirements apply to the portion of premium paid beyond the month in which the cancellation is effective.

This legislation applies to individually marketed individual health insurance, Medicare supplement insurance and long-term care insurance policies that are issued, delivered or renewed on or after July 12, 2006.

*Contact: Health Insurance Policy and Managed Care Division
(502) 564-6088*

House Bill 374 – Administrative Regulations

This bill makes several changes to the process for promulgating administrative regulations.

KRS 13A.240, relating to the Regulatory Impact Analysis, is amended to require an “analysis” versus an “assessment” of how the entities affected by the regulation will be impacted by its implementation. The analysis is to include:

- a detailed explanation of the actions the entities will be required to undertake to comply with the regulation;
- an estimate of the costs imposed on the entities in order to comply; and
- a statement regarding the benefits that may accrue as a result of compliance.

KRS 13A.250 is amended to require a cost analysis of the projected cost or cost savings to the Commonwealth and local governments, including fire departments and school districts. A fiscal note must be submitted if a regulation relates to any aspect of state or local government.

The process for notifying interested persons that regulations have been filed was amended. Rather than completing an agency’s notification form, persons wishing to be notified when regulations are filed are required to either (1) contact the agency by telephone or written letter to request information; or (2) complete an electronic registration form on a centralized database. If contacting an agency by letter, the letter must indicate whether the interested party wants notification of all filed regulations or specified subject areas. A request to be notified of filed regulations is valid for four (4) years from the date the request is submitted or until removal from the registration list is requested.

A new statute in KRS Chapter 11 was created to require each Cabinet to designate a small business ombudsman from existing staff. The duties of the small business ombudsman include:

- responding to inquiries from small business on regulations and other regulatory matters;
- providing information on procedures for submitting comments on regulations; and
- preparing a report to the Commission on Small Business Advocacy by December 1st of each year which summarizes the number and nature of inquiries received during the year.

The contact information for the small business ombudsman is required to be listed on the Cabinet’s Web site.

Contact: Executive Director's Office
(502) 564-6026

House Bill 380 Part 23 – Insurance Coverage Affordability and Relief to Small Employers (ICARE)

Part 23 of HB 380 creates the Insurance Coverage Affordability and Relief to Small Employers (ICARE) Program, a 4-year pilot program for small employer groups of 2 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 program is effective January 1, 2007.

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% of the Federal Poverty Level. Further, the employer must pay 50% 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 4-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 4-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 23 of HB 380 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.
- **Patient credit protection**
 - Directs the Office of Insurance to conduct a study to determine the impact to the insured being “balance billed” by providers; and
 - Requires the study to be completed by December 31, 2006.
- **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% annually for claims paid between one (1) and 30 days late and 14% annually for claims over 31 days late; and
 - Updates requirement for acknowledgement to allow reasonableness for determination of claims status.

*Contact: Health Insurance Policy and Managed Care Division
(502) 564-6088*

House Bill 380 Part 34 – Captive Insurers

Part 34 of HB 380 amends various statutes in KRS Subtitle 304, Subtitle 49, related to captive insurers.

Section 1 creates a new statute within KRS 304 Subtitle 49 to:

- Require a captive insurer to have a manager who is a resident of Kentucky;
- Require a captive manager to maintain a captive insurer's records at a location in Kentucky or to make them available to the executive director at a location in Kentucky;
- Require the captive manager to notify the executive director if the captive insurer fails to comply with the requirements; and
- Allow the executive director to require that a captive manager be discharged for failure to fulfill his or her duties.

Section 2 creates a new statute within KRS 304 Subtitle 49 to allow the executive director to promulgate regulations to set minimum standards for the formation, structure examination and operation of a special purpose captive insurer.

Section 3 creates a new statute within KRS 304 Subtitle 49 to require a captive insurer to:

- notify the executive director in writing within ten (10) business days of any material change in the financial condition or management of a captive insurer; and
- provide 30 days prior written notice and receive approval by the executive director of specified material transactions.

Section 4 creates a new statute in KRS 304 Subtitle 49 to allow a sponsored captive insurer to establish and maintain one or more protected cells under the following conditions:

- The owners can only be participants and sponsors except that the executive director may approve the issuance of nonvoting securities or interests to other persons.
- The assets of each protected cell must be held and accounted for separately.
- The assets of a protected cell are not chargeable with liabilities of any other protected cell or of the sponsored captive insurer generally, unless otherwise agreed in the participant contract.
- A captive insurer cannot sell or transfer assets or pay a dividend or other distribution from the protected cell without the consent of the participants.
- The executive director must approve any sale, exchange, or transfer of assets or payment of a dividend or other distribution that is not made in accordance with the participant contract.
- On an annual basis, a sponsored captive insurer must file financial reports with the executive director detailing the financial experience of each protected cell.

- A sponsored captive insurer shall provide written notification to the executive director within ten (10) business days of any protected cell that is insolvent or unable to meet its claims or expense obligations.
- The executive director must provide prior written approval of a new participant contract, addition of a new protected cell, withdrawal of any participant or termination of any existing protected cell.
- The business written by a sponsored captive insurer for a protected cell must be fronted by a licensed insurance company, reinsured by an authorized reinsurer, secured by a trust fund in Kentucky, or funded by an irrevocable letter or credit or other arrangement acceptable to the executive director. The executive director may require additional security.

Section 5 amends KRS 304.49-010 to add new definitions for “agency captive insurer” and “special purpose captive insurer.”

Section 6 amends KRS 304.49-020 to:

- Prohibit captive insurers issued a certificate of authority on or after July 1, 2006, from directly providing workers’ compensation insurance;
- Designate as confidential portions of the license application, examination reports, preliminary examination reports, working papers and other documents related to the examination unless prior written consent has been given by the captive insurer; and
- Allow the confidential records to be provided to other insurance regulators, law enforcement officials and government officials as long as they agree, in writing, to hold the records confidential.

Section 7 amends KRS 304.49-040 to require minimum initial and on-going capital and surplus of \$500,000 for an agency captive insurer and \$250,000 or another amount determined by the executive director for a special purpose captive insurer.

Additionally, this section allows capital and surplus to be in the form of other assets approved by the executive director.

Section 8 amends 304.49-060 to:

- Allow a special purpose captive insurer to be incorporated as a stock or nonstock corporation; formed as a limited liability company, partnership, limited partnership or statutory trust; or formed as a different entity approved by the executive director other than a natural person;
- Allow a sponsored captive insurer to be incorporated as a stock or nonstock corporation; or formed as a limited liability company, partnership, limited partnership, or statutory trust;

- Allow a risk retention group to take any form permitted under the federal Liability Risk Retention Act of 1986; and
- Require each owner of an agency captive insurer to be a licensed insurance producer.

Section 9 amends KRS 304.49-070 to:

- Allow the executive director to approve the captive insurer's use of international accounting standards, with any appropriate modifications;
- Allow a captive insurer who is using statutory accounting principles (as approved by the executive director) to make modifications necessary to record as admitted the full value of all permitted investments; and
- Allow captive insurers not formed as a risk retention group to file financial reports on a form prescribed by the executive director. Requires a captive insurer formed as a risk retention group to file financial reports in accordance with KRS 304.2-205 (the applicable form for private insurance companies) with any modifications prescribed by the executive director.

Section 10 amends KRS 304.49-100 to allow the executive director to approve investments outside of the scope of the statute if they are reasonable, prudent and would not tend to adversely affect the financial condition of the captive insurer. Additionally, this section Removes the applicability of KRS 304.37-030 regarding material transactions.

*Contact: Financial Standards and Examination Division
(502) 564-6082*

House Bill 418 – Final HIPAA Rules on Portability; Cost Sharing for Chiropractors

This bill amends various provisions of KRS 304 Subtitle 17A.

Section 1 amends the definition of “creditable coverage” and “excepted benefits”, and adds new definitions for “dependent”, “employee benefit plan”, “group health plan”, and “participant” in KRS 304.17A-005 to conform to the final federal rules related to the portability provisions in HIPAA.

Additionally, the definition for “individual market” was amended to clarify that associations of individuals that are not employer related are included in the definition.

Section 2 amends KRS 304.17A-220 related to pre-existing condition exclusions and the method for determining any reduction in the exclusion period based on creditable coverage. This section also amends the definitions of “pre-existing condition exclusion”, “enrollment date”, and “waiting period” and includes new definitions for “first day of coverage”, “late enrollee”, “late enrollment”, and “significant break in coverage” to mirror the final federal rules.

More specifically, the legislation provides for the following changes:

- Only conditions for which medical advice, diagnosis, care or treatment recommended by or received from an individual licensed or authorized under state law to provide the services are considered pre-existing conditions.
- The six (6) month “look back” time frame for determining whether a condition is pre-existing begins on the six (6) month anniversary date preceding the enrollment date.
- The exclusion period may be reduced by the number of days of creditable coverage an individual has as of the effective date of coverage under the policy.
- An insurer is allowed to impose a pre-existing exclusion period beginning with the effective date of coverage for non-HIPAA eligible individuals.
- The insurer must provide written notice to participants in order to impose a pre-existing condition exclusion. If information regarding creditable coverage is received, the insurer must provide written notice of the length of the exclusion period that remains after the offset for creditable coverage has been made.
- The days in the waiting period are not counted as creditable coverage.
- The days before a significant break in coverage are not required to be counted as creditable coverage.
- The days in a waiting or affiliation period are not taken into account when determining if a significant break has occurred.
- If an individual seeks coverage in the individual market, the waiting period begins on the date the individual submits a substantially completed application for coverage and ends on:
 - The day coverage begins (if the application results in coverage); or
 - The date on which the application is denied by the insurer or the offer for coverage lapses (if the application does not result in coverage).
- An insurer is prohibited from imposing a pre-existing condition exclusion based solely on genetic information. However, an insurer may impose a pre-existing condition exclusion if the individual is diagnosed with a condition even if the condition relates to genetic information.
- The legislation adds the following events that qualify an employee or dependent for special enrollment:
 - Cessation of dependent status;
 - Meeting or exceeding a lifetime limit on all benefits;
 - The employee or dependent’s plan no longer offers any benefits to the class of similarly situated individuals; or
 - The employee or dependent is covered through a plan that does not provide benefits to members who no longer reside, live or work in the service area, and the employee or dependent no longer resides, lives or works in the plan’s service area.

- An insurer must allow thirty (30) days after the qualifying event for an employee or dependent to request enrollment. Coverage must begin no later than the first day of the first calendar month after the date the insurer receives the request for enrollment.

Sections 3 through 8 provide conforming amendments.

Section 9 amends KRS 304.17A-617 to allow an insurer ten (10) business days to respond to a request for information from the Office of Insurance regarding a coverage denial.

Sections 10 through 12 prohibit an insurer from imposing a copayment or coinsurance amount for services rendered by a chiropractor or an optometrist that is greater than the amount charged for the services of a physician or osteopath for the same or similar diagnosed condition. This prohibition applies to coverage through a health benefit plan, including a plan issued by Kentucky Access, and a limited health service benefit plan.

*Contact: Health Insurance Policy and Managed Care Division
(502) 564-6088*

House Bill 561 – Insurance Producers

This bill amends KRS 304.9-040 and 304.9-080 to allow a business entity to be licensed as a consultant. The bill further amends KRS 304.9-320 to set forth the process for licensure. To be licensed as a consultant, a business entity must:

- Complete the NAIC Uniform Business Entity License Application;
- Pay the applicable fee;
- Be competent, trustworthy of high fiduciary standards, financially responsible and of good business reputation; and
- Designate each individual licensed as a consultant to act under its license.

House Bill 561 offers a licensing alternative for consultants but does not alter the duties and responsibilities of a consultant pursuant to KRS Chapter 304, Subtitle 9. Business entity consultants and individual consultants will be subject to the same laws governing the actions and practices of a consultant as outlined in Subtitle 9.

The bill also amends KRS 304.9-107 to clarify that an individual who holds a specified professional designation is exempt from pre-licensing training, but must successfully pass the licensing examination in order to be licensed as an agent.

*Contact: Agent Licensing Division
(502) 564-6004*

House Bill 572 – Drug Testing of Miners

Sections 1 and 6 of this bill allow for a premium credit for a workers' compensation insurance policy issued to a licensed employer who has implemented a drug free workplace program certified by the Office of Mine Safety and Licensing. The credit must be actuarially sound and must be at least 5%, unless that percentage amount is found by the Office of Insurance to be actuarially unsound. The credit may be applied at the time of the final audit.

To be eligible for the credit, the employer must maintain the program for the entire policy period.

This credit is not applicable to minimum premium policies.

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

Other Insurance-Related Legislation

Senate Bill 19 – Kentucky Electronic Health Network

This bill amends KRS 216.267 to allow the Kentucky Electronic Health Network (Ke-HN) to serve as a registry for advance directives related to health care, advance directives related to mental health treatment, and organ donations.

Senate Bill 44 – Quick Clearance

This bill amends KRS 189.580 related to the duties of individuals involved in traffic accidents.

Quick Clearance

This bill requires an operator involved in a non-injury accident on an interstate, parkway or ramp to move his or her vehicle off the roadway to a place as close to the accident scene as possible without obstructing traffic. The bill allows a peace officer or safety officer to remove a vehicle or other property without the consent of the owner or operator of the vehicle if the property is obstructing the roadway, creating an aggravating or emergency situation, or otherwise endangering public safety.

The requirements of the bill would not apply if the accident involved death, visible injury or the transportation of hazardous materials. In instances involving death or visible injury, the vehicle and any other property would be removed from the roadway only after medical assistance, fire supervision and site investigation are complete. In instances involving a release of hazardous materials, the removal requirements do not apply.

Reporting of Accidents

The operator of a motor vehicle involved in an accident is required to notify a public safety answering point or a law enforcement agency or officer of the accident if he or she is capable of communication and has a functioning communications device. If the operator is unable to report, the owner of the vehicle or an occupant in the vehicle is required to report if they are physically capable and have a functioning communications device. If the owner or an occupant is unable to report the accident, a law enforcement officer is required to investigate and file a written report.

If the investigation is not conducted by a law enforcement officer and the accident occurred on a Kentucky highway and resulted in death, injury, or property damage of at least \$500, the operator is required to file a written report within ten (10) days of the date of the accident.

Recovery of Costs

An agency that removes property from the road is permitted to intervene in a civil action to recover the cost of removal. An owner of real property is not liable for the costs for removal of trees, fences, structures or other debris that falls on the roadway.

Senate Bill 180 – Primary Health Care for the Uninsured

This bill creates a new section of KRS Chapter 211 that instructs the Cabinet for Health and Family Services to establish and operate the Kentucky Physicians Care Program, if funds are available. The purpose of the program is to assist low income uninsured individuals in accessing primary health care services provided by volunteer health care practitioners and pharmacy drugs donated by pharmacy companies.

The eligibility criteria for the program requires applicants to:

- Have a gross income limit of 100% of the federal poverty level;
- Have a resource limit of \$2,000;
- Not be qualified for a government assistance program; and
- Not be covered by a health benefit plan.

Once approved, an individual is eligible to be in the program for one year, but the individual may reapply.

The bill permits the program to:

- Operate and maintain a toll-free hotline referral service;
- Maintain records;
- Provide client referrals;
- Create temporary volunteer advisory committees;
- Apply for and accept funds; and
- Contract with an independent third party to provide services.

House Bill 117 – Primary Enforcement of the Seat Belt Law; ATV Helmet Law

This bill includes two (2) main provisions impacting the insurance industry.

Seat Belts

This legislation amends KRS 189.125 to require a person operating a vehicle manufactured after 1981 to wear a seat belt. Further, the legislation allows police to stop a person for failure to wear a seat belt, rather than requiring that they be stopped for another offense. A conviction for not wearing a seat belt will not become part of an individual's driving record and is not subject to court costs.

ATV Helmets

This legislation also amends KRS 189.515 to require a person under the age of sixteen (16) to wear approved protective headgear when operating or riding on an all-terrain vehicle.

House Bill 90 – Graduated Driver License

This bill amends KRS 186.450 to create a three tier driver licensing program including an instruction permit, an intermediate license and an operator license.

Instruction Permit

This legislation makes an instruction permit valid for three (3) years rather than one (1) year.

An individual that is 16 to 18 years of age at the time of application for an instructional permit must wait a minimum of 180 days before applying for an intermediate license. (Individuals who are between the ages of 18 and 21 must wait 180 days before applying for an operators license.) Citations for specific moving violations add an additional 180 days, at a minimum, to the waiting period before applying for an intermediate license.

Drivers who are under the age of 18 may not operate a vehicle at any time when the vehicle is occupied by more than one unrelated person under the age of 20, unless they are with a driver training instructor.

Intermediate License

To apply for an intermediate license, an individual must:

- Have held an instructional permit for at least 180 days;
- Be at least 16 ½ years old;
- Have no moving violations; and
- Have 60 hours of supervised driving accompanied by a licensed driver who is at least 21 years of age, including ten (10) hours at night.

To receive an intermediate license, an applicant must pass an exam. An intermediate license is valid for two (2) years, and includes restrictions on driving between 12:00 am and 6:00 am except for good cause shown for licensed individuals under the age of 18. Additionally, an individual holding an intermediate license can not have more than one (1) passenger under the age of 20 who is not related to the driver.

Operator License

An individual can apply for an operator license if he or she has held an intermediate license for at least 180 days, has no moving violations, and completes a driver training course. (If an individual was cited for specified moving violations while holding an intermediate license, he or she must wait at least an additional six (6) months before applying for an operator license.)

House Bill 272 – Quick Clearance

This is a companion bill to SB 44. Please refer to the summary for that bill.

R. Glenn Jennings
Executive Director
Kentucky Office of Insurance

Date