COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, Kentucky

BULLETIN 2021-002

INSURANCE LEGISLATION ADOPTED BY THE
2021 KENTUCKY GENERAL ASSEMBLY (REGULAR SESSION)

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 2021 ACTS OF THE KENTUCKY GENERAL ASSEMBLY ARE PUBLISHED IN THE SUMMER OF 2021. UNLESS OTHERWISE NOTED, THE EFFECTIVE DATE OF LEGISLATION IS JUNE 29, 2021.

(Bills as enacted are available on the LRC website at http://www.lrc.ky.gov/record/21RS/law.htm)

House Bill 48- An Act Relating to Reimbursement for Pharmacist Services (Act Ch. 30)

This Act creates a new statute within Subtitle 12 of KRS 304 to require insurers or third party administrators to provide reimbursement to a pharmacist for a service or procedure at a rate not less than that provided to other non-physician practitioners. The requirement applies if the service or procedure:

- Is in the scope of the practice of pharmacy
- Is performed by the pharmacist in compliance with laws and regulations related to the pharmacist's license; and
- Would be otherwise covered under the plan if the service or procedure was provided by a physician, advanced practice registered nurse, or a physician assistant.

To the extent permitted under federal law, the requirements apply to an insurer, self-insurer, self-insured plan, self-insured group, health maintenance organization, provider-sponsored integrated health delivery network, or nonprofit hospital, medical-surgical, dental, and health insurance service corporation.

In consideration of the reimbursement requirements, KRS 304.14-135 is amended to clarify that a clean claim for pharmacists includes:

- A universal claim form approved by the National Council for Prescription Drug Programs for prescription drug claims; and
- For all other claims or services within the scope of practice of pharmacy, a health insurance claim form submitted on paper or electronic format as adopted by the National Uniform Claim Committee.

Finally, the Act amends KRS 18A.225 related to the state employee health plan and KRS 342.020 related to workers' compensation coverage to apply the reimbursement requirements to coverage under those plans.

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

House Bill 50 – An Act Relating to Mental Health Parity (Acts Ch. 15)

This Act amends KRS 304.17A-660 and KRS 304.17A-661 to adopt the requirements of the federal Mental Health Parity and Addiction Equity Act related to nonquantitative treatment limitations.

Additionally, the Act requires an insurer that issues or renews a health benefit plan that is subject to the mental health parity requirements to submit an annual report to the commissioner by April 1 of each year that contains:

- A description of the process used to develop or select the medical necessity criteria for both mental health condition benefits and medical and surgical benefits;
- Identification of all nonquantitative treatment limitations applicable to benefits and services covered under the plan that are applied to both mental health condition benefits and medical and surgical benefits within each classification of benefits; and
- The results of an analysis that demonstrates compliance with the mental health parity requirements for each nonquantitative treatment limitation identified including:
    - The factors used to determinate that a nonquantitative treatment limitation will apply to a benefit including factors that were considered but rejected;
    - The specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation; and
    - The comparative analysis and the results of that analysis used to determine that the written and operational processes and strategies for each nonquantitative treatment limitation applied to mental health condition benefits are comparable to and applied no more stringently than those for medical and surgical benefits.

The commissioner will determine the format of the annual report and the manner in which it will be submitted through an administrative regulation.

This requirements of this Act are effective on January 1, 2022.

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

House Bill 75 – An Act Relating to Living Organ Donation (Acts Ch. 55)

This Act creates a new statute within KRS Chapter 304, Subtitle 12 to prohibit:

- Limiting or declining to issue or renew insurance coverage solely due to the status of an individual as a living organ donor;
- Precluding an insured from donating all or part of an organ as a condition of continuing to receive insurance coverage; or
- Otherwise discriminating in the offering, issuance, cancellation, amount of insurance coverage, price, or any other condition of insurance coverage based solely upon the status of an individual as a living donor.

For the purposes of this Act, "insurance coverage" is defined to mean disability insurance, life insurance, or long-term care insurance.

The provisions of this Act apply to policies issued and renewed on or after June 29, 2021.

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

House Bill 95 – An Act Relating to Prescription Insulin (Acts Ch. 75)

This Act amends KRS 304.17A-148 to limit the cost-sharing for a covered prescription insurance drug to $30 per 30 day supply regardless of the amount or type of insulin needed to meet the covered person's insulin needs. The Act specifically allows insurers to establish cost-sharing requirements for covered prescription insulin drugs below the statutory limit.

For the purposes of this statute, "cost-sharing" has the same meaning as in KRS 304.17A-164, which includes the cost to an individual insured under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan.

The provisions of this Act apply to the state employee health plan, but do not apply to other governmental self-insured plans. Additionally, as the Act relates to health benefit plans, the provisions impact grandfathered, transitional, non-grandfathered plans, and catastrophic plans.

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

House Bill 140 – An Act Relating to the Telehealth (Acts Ch. 67)

This Act creates a comprehensive approach to the delivery of and payment for telehealth services within the Commonwealth of Kentucky.

The following changes were made with respect to private health insurance:

- A uniform definition of "telehealth" or "digital health" was created to mean a mode of delivering health care services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient

or to another health care provider at a different location. Services must be provided over HIPAA compliant platforms unless waived by the applicable federal authority.

- The definition of "telehealth" or "digital health" specifically excludes:
    - e-mail, text, chat or facsimile unless a state agency, through the promulgation of an administrative regulation, determines that health care services can be delivered through these modalities in ways that enhance the health and well-being of the recipient and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; and
    - Basic communication between a health care provider and a patient such as appointment scheduling, appointment reminders, and voicemail.

- The mandated benefit for telehealth in KRS 304.17A-138 was amended to:
    - Require reimbursement for home health services provided through telehealth;
    - Require reimbursement to rural health clinics, federally qualified health centers, and federally qualified health center look-alikes as an originating site in an amount equal to the allowable reimbursement amount for Medicare-participating providers if the insured was physically located at the clinic or center at the time of service and the provider is not employed by the clinic or center;
    - Require that telehealth services meet all clinical, technology, and medical coding guidelines for recipient safety and appropriate delivery of services;
    - Require a telehealth provider to be licensed in Kentucky or as allowed under the standards and provisions of a recognized interstate compact, in order to receive reimbursement for telehealth services; and
    - Allow an insurer to utilize audits for medical coding accuracy in the review of telehealth services specific to audio-only encounters.

- Section 3 of the Act requires any state agency authorized or required to promulgate administrative regulations relating to telehealth, including the Department of Insurance, to use terminology consistent with the glossary developed by the Division of Telehealth Services within the Office of Health and Data Analytics. Additionally, this section prohibits state agencies from:
    - Requiring a provider to be physically present with the recipient unless the state agency or provider determines that it is medically necessary to perform those services in person;
    - Requiring prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;
    - Requiring a provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person;
    - Requiring demonstration that it is necessary to provide services to a patient through telehealth;

- Requiring demonstration that it is necessary to provide services to a patient through telehealth
- Restricting or denying coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services;
- Prohibiting the delivery of telehealth services to a person located in Kentucky by a provider who is a participant in a recognized interstate compact and delivers telehealth services under the standards and provisions of that interstate compact;
- Prohibiting an insurer or managed care organization from utilizing audits for medical coding accuracy in the review of telehealth services specific to audio-only encounters; or
- Requiring a provider to be part of a telehealth network.

- Section 4 specifically excludes workers' compensation insurance from the provisions of the Act.

Finally, the Act:

- Requires the Division of Telehealth Services within the Office of Health and Data Analytics within the Cabinet for Health and Family Services to:
  - Provide guidance and direction to providers delivering health care services using telehealth or digital health;
  - Develop guidance, resources, and education to help promote access to health care services provided via telehealth or digital health;
  - Maintain an online telehealth provider directly for consumer use; and
  - Promulgate an emergency administrative regulation to establish:
    - A glossary of telehealth terminology to provide standard definitions for all healthcare providers who deliver health care services via telehealth, all state agencies authorized or required to promulgate regulations related to telehealth, and all payors;
    - Establish minimum requirements for the proper use and security of telehealth including requirements for confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology;
    - Minimum requirements to prevent waste, fraud, and abuse related to telehealth; and

- Requires the Cabinet for Health and Family Services to provide an annual report to the Legislative Research Commission by December 1 of each year including an analysis of the impact of telehealth on the health care delivery system in Kentucky and the Medicaid budget.

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

House Bill 196 – An Act Relating to the Prohibition of Patriot Penalties in Insurance (Acts Ch. 17)

This Act creates a new statute within KRS Chapter 304, Subtitle 20 to prohibit an insurer from refusing to issue a policy of motor vehicle liability insurance or imposing an additional premium solely because the person is:

- Uninsured at the time of application; and
- During the period the person was without insurance, the person was on military service and absent from the Commonwealth.

Upon application, the Act requires the insurer to request whether the person was on military service during the time the person was uninsured. The insurer is permitted to request reasonable documentation to verify the person's military service.

An insurer will be found to commit an unfair trade practice if it demonstrates a willful pattern of noncompliance with the requirements of this Act.

As the Act relates to a policy of motor vehicle liability insurance, the provisions of this Act could impact insurance covering any type of motor vehicle included in the definition of KRS 186.010.

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

House Bill 250 – An Act Relating to the Regulation of Travel Insurance (Acts Ch. 36)

This Act creates a new Subtitle 52 within KRS Chapter 304 to establish a comprehensive regulatory scheme for travel insurance. Travel insurance is defined to mean insurance coverage for personal risks incident to planned travel, including:

- Interruption or cancellation of a trip or event;
- Loss of baggage or personal effects;
- Damages to accommodations or rental vehicles;
- Sickness, accident disability, or death occurring during travel;
- Emergency evacuation;
- Repatriation of remains; or
- Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel, as approved by the commissioner.

Travel insurance specifically does not include insurance coverage that provides comprehensive medical protection for travelers with trips lasting longer than six (6) months, including but not limited to those working or residing overseas as an expatriate or any other product that requires a specific insurance producer license.

Scope

The Act applies to travel insurance that covers a resident of Kentucky and is sold, solicited, negotiated, or offered in the state. Further, the Act does not apply to cancellation fee waivers and travel assistance services.

Offering and Disseminating Travel Insurance

Section 3 outlines the requirements for the offering and disseminating of travel insurance by unlicensed persons. Under these provisions, a travel retailer can offer and disseminate travel insurance without holding a license from the Department of Insurance under the following conditions:

- The travel retailer must be supervised by a business entity limited lines travel insurance producer;
- The following information is provided to a purchaser of travel insurance:
    - A description of the material terms or the actual material terms of the insurance coverage;
    - A description of the process for filing a claim;
    - A description of the review or cancellation process for the travel insurance policy; and
    - The identity and contact information of the insurer and the limited lines travel insurance producer.

A travel insurance retailer cannot:

- Evaluate or interpret the technical terms, benefits, and conditions of the travel insurance coverage;
- Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or
- Hold himself or herself out as a licensed or authorized insurer, licensed insurance agent, or insurance expert.

In its supervisory role, the business entity limited lines travel insurance producer must:

- Establish and maintain a register of each travel retailer that it supervises;
- Submit the register to the commissioner upon request;
- Certify that the travel retailers that it supervises comply with 18 USC 1033;
- Designate an individual limited lines travel insurance producer as the person responsible for compliance; and
- Require each employee and authorized representative of the travel retailer who will be offering and disseminating travel insurance to receive a program of instruction and training including, at a minimum, adequate instruction on the type of insurance offered, ethical sales practices, and required disclosures to prospective insureds.

For purpose of this Act, a limited lines travel insurance producer means a properly licensed:

- Managing general agent;
- Administrator;
- Insurance agent holding the applicable line of authority;
- Limited lines travel insurance agent; or
- Surplus lines broker.

Travel Insurance Brochures or Other Written Materials

The information made available to prospective purchasers of travel insurance must:

- Be approved by the insurer providing the travel insurance; and
- Contain the following:
    - The identity and contact information of the insurer and the limited lines travel insurance producer;
    - An explanation that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and
    - An explanation that a travel retailer that is not licensed is permitted to provide only general information about the travel insurance including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the travel insurance or to evaluate the adequacy of the customer's existing insurance coverage.

Requirements for Travel Protection Plans

Section 4 of the Act permits travel protection plans to be offered for a single price if:

- The plan clearly discloses to the consumer at the time of purchase or prior to purchase that:
    - It includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable; and
    - The consumer has the opportunity to obtain additional information regarding the features and pricing of the components of the travel protection plan;
- The fulfillment materials describe the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan and comply with the requirements for travel insurance brochures or other written materials; and
- Do not contain negative options or opt outs (as more fully described below).

"Travel protection plan" is defined as a plan that provides one or more of the following:

- Travel insurance;
- Travel assistance services; or
- A cancellation fee waiver.

"Fulfillment materials" are defined as documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's travel insurance coverage and travel assistance services details.

Business Practices in the Sale of Travel Insurance

Section 5 of the Act subjects persons offering travel insurance in Kentucky to the requirements in KRS 304, Subtitle 12 and establishes the following prohibited practices specific to the sale of travel insurance:

- Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy;
- Marketing blank travel insurance as free; or
- Offering, soliciting, or negotiating travel insurance through the use of a negative option or opt-out, which would require a consumer to take an affirmative action to deselect coverage, including unchecking a box on an electronic form, when the consumer purchases a trip.

This section specifically permits the following actions:

- Providing an accurate summary or short description of coverage on an insurer's website or through an aggregator site that markets travel insurance directly to the consumer if the consumer has access to the full provisions of the travel insurance policy through electronic means; and
- When a consumer's destination jurisdiction requires insurance coverage, requiring a consumer to choose between the following options as a condition of purchasing a trip or travel package:
    - Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer; or
    - Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

This section further requires:

- All sales materials, advertising, and marketing materials provided to consumers prior to the purchase of travel insurance to be consistent with the form and rate filing;
- For travel insurance policies containing pre-existing condition exclusions, information be provided to the consumer prior to the time of purchase and in the fulfillment materials regarding the exclusion;
- The fulfillment materials and the required disclosures be provided as soon as practicable after the purchase of a travel protection plan;
- A full refund of the travel protection plan price if:
    - The covered trip has not started;
    - A claim has not been filed; and
    - The policy is canceled sometime during the time period from the date of purchase until at least fifteen (15) days following the date of delivery by postal mail or ten (10) days following the date of delivery by other means.
- The policy documentation and fulfillment materials to state whether the travel insurance is primary or secondary to other insurance.

Licensure Exemptions

Section 6 of the Act permits a licensed managing general agent, administrator, or insurance agent with a property and casualty line of authority to adjust or settle claims in connection with travel insurance without an adjuster license. This section also makes an insurer responsible for the acts of a licensed managing general agent, administrator, or agent administering travel insurance underwritten by the insurer and ensuring that these licensees maintain books and records relevant to the insurer, which are required to be made available to the commissioner upon request.

Rate and Form Filings

In general, travel insurance is required to be classified and filed as inland marine insurance. If the travel insurance provides coverage for sickness, accident, disability, or death occurring during travel either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, it may be classified as health insurance.

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

Property and Casualty Division
(502) 564-6046

SB 44 – An Act Relating to the Payment of Insurance Premiums and Cost Sharing on Behalf of an Insured Acts Ch. 133)

This Act creates a new statute in KRS Chapter 304, Subtitle 17A to require insurers to accept payment of premium or cost-sharing made on behalf of an insured by the following entities:

- State or federal government programs including payments made for the delivery of essential services to individuals and families with HIV;
- Indian tribes, tribal organizations, or urban Indian organizations; and
- A program conducted by a tax exempt charitable organization operating in accordance with federal laws.

Insurers are permitted, but not required, to accept payments from other third parties.

The Act clarifies:

- Insurers are not required to accept contributions to the minimum deductible for high deductible health plans if accepting the contributions would result in the corresponding health savings account losing its tax exempt status under IRS laws;
- Insurers are not required to accept third party premium payments made by or on behalf of any organization that receives funding from a health care provider; and
- Insureds are ultimately responsible for the timely payment of premium.

The Act relates to health benefit plans including grandfathered, transitional, and non-grandfathered plans. The provisions are effective on January 1, 2022.

Additionally, the Act amends KRS 214.555 to change the sunset provision on notification by a physician to a patient of dense breast tissue following a mammogram from January 1, 2021 to January 1, 2025.

Contact: Health and Life Insurance and Managed Care Division
502-564-6088

Senate Bill 45 – An Act Relating to Prescription Drugs (Acts Ch. 134)

This Act amends KRS 304.17A-164 to prohibit an insurer or pharmacy benefit manager from excluding cost-sharing paid by an insured or on behalf of an insured for a prescription drug by another person when calculating an insured's contribution to cost-sharing. The prohibition does not apply if there is a generic alternative unless the insurer has prior approved the use of the brand name drug.

The definition of "health plan" in this Act includes health benefit plans and "a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services." However, the provisions of this Act do not apply to the state employee health plan.

Additionally, it should be noted that the provisions only apply to the extent permitted by federal law. Therefore, based on guidance from the Internal Revenue Service in IRS Notice 2004-50 Q&A-9, the provisions of the Act do not apply to the amount accumulated towards the deductible applied to high deductible health plans paired with a health savings account.

This Act has an effective date of January 1, 2022.

Contact: Health and Life Insurance and Managed Care Division
502-564-6088

Senate Bill 51 – An Act Relating to Addiction Treatment (Acts Ch. 201)

Section 1 of the Act amends KRS 304.17A-611 to prohibit an insurer from requiring or conducting a prospective or concurrent review for a prescription drug that:

- contains methadone, buprenorphine or naltrexone and is used in the treatment of alcohol or opioid use disorder; or
- was approved before January 1, 2022 by the US Food and Drug administration for the mitigation of opioid withdrawal symptoms.

This requirement specifically relates to coverage under a health benefit plan that is issued or renewed on or after January 1, 2022. Further, Section 2 of the Act amends KRS 205.536 to apply these same requirements to Medicaid benefits provided through the Department for Medicaid Services or a Medicaid managed care organization.

Section 3 of the Act creates a new subtitle in KRS 304 Subtitle 17A to require an insurer to annually report to the commissioner the number and type of providers that have prescribed medication for addiction treatment to its insureds in conjunction with behavioral therapy and not in conjunction with behavioral therapy. The Commissioner is required to submit an annual written report to the General Assembly, State Board of Medical Licensure, and the Kentucky Board of Nursing summarizing this information.

"Insurer" is defined in KRS 304.17A-005(29) to mean any of the following entities licensed to transact health insurance in Kentucky: insurance company; health maintenance organization; self-insurer including a governmental plan, church plan, or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; or nonprofit hospital, medical-surgical, dental, or health service corporation.

Additionally, Section 4 of the Act amends KRS 205.522 to specifically require Medicaid managed care organizations to report this information to the Department of Insurance.

This Act has a delayed effective date of January 1, 2022.

Contact: Health and Life Insurance and Managed Care Division
502-564-6088

SB 154 – An Act Relating to Home Health Care and Declaring an Emergency (Acts Ch. 59)

Section 2 amends the definition of "home health care" in KRS 304.17-312 to add an advanced practice registered nurse and a physician assistant to the list of providers that can prescribe and supervise the care and treatment provided by a home health agency.

In accordance with the change to the definition, sections 3, 4, and 5 of the Act amend KRS 304.17-313, KRS 304.18-037, and KRS 304.38-210 respectively to add an advanced practice registered nurse or a physician assistant to the list of providers that can certify that confinement would be necessary if home health care were not provided for the purpose of reimbursement under a health insurance policy.

This Act became effective on March 22, 2021, upon the Governor's signature.

Contact: Health and Life Insurance and Managed Care Division
502-564-6088

Additional Bills of Interest

House Bill 273 – An Act relating to public records and declaring an emergency (Acts Ch. 78)

This Act excludes from Kentucky's open records law photographs or videos that depict the death, killing, rape, or sexual assault of a person. The Act includes the ability of specific parties,

including any involved insurance company or its representative, to view the photographs or videos on the premises of the public agency or a mutually agreed upon location.

House Bill 307– An Act Relating to Cannabinoid Products (Acts Ch. 123)

This Act amends the definition of marijuana in KRS 281A.010 to add a cannabinoid product derived from industrial hemp for the purpose of conducting scientific research, as defined in KRS 260.850. Kentucky requires adherence to these statutory definitions in any form and rules filings submitted to the Department.

House Bill 312 – An Act Relating to Public Records (Acts Ch. 160)

This Act amends the definition of who may request a public record from any person to "residents of the Commonwealth." Residents of the Commonwealth is defined very broadly to include individuals who reside, work, or own property in Kentucky, domestic businesses with a location in Kentucky, foreign businesses registered with the Secretary of State, any business that owns property in the state, certain news-gathering organizations, and certain agents of Commonwealth residents.

House Bill 509 – An Act Relating to Reorganization (Acts Ch. 24)

This Act amends KRS 12.020 to confirm Executive Order 2020-1028 reorganizing the Department of Insurance by:

- Abolishing the Division of Insurance Product Regulation and creating two divisions: the Division of Health and Life Insurance and Managed Care and the Division of Property and Casualty Insurance; and
- Renaming the Division of Agent Licensing to the Division of Licensing.

House Joint Resolution 57 - A Joint Resolution directing the Cabinet for Health and Family Services to establish a work group to assess the feasibility of implementing a bridge insurance program, to review current Temporary Assistance for Needy Families expenditures, and to consider opportunities for public-private partnerships to better meet the needs of public assistance beneficiaries (Acts Ch. 128)

This joint resolution directs the Cabinet for Health and Family Services to establish a work group to study various public assistance programs including the feasibility of implementing a bridge insurance program. The work group is required to include at least the following members:

- The Secretary of the Cabinet for Health and Family Services, or his or her designee;

- The Secretary of the Education and Workforce Development Cabinet, or his or her designee;
- The Executive Director of the Kentucky Workforce Innovation Board, or his or her designee;
- The Executive Director of the Kentucky Association of Health Plans, or his or her designee;
- The Commissioner of the Department of Insurance, or his or her designee;
- The Commissioner of the Department for Community Based Services, or his or her designee;
- The Commissioner of the Department for Medicaid Services, or his or her designee;
- The President of the Kentucky Retail Federation, or his or her designee;
- The President of the Kentucky Chamber of Commerce, or his or her designee;
- Two members of Kentucky House of Representatives; and
- Two members of the Kentucky Senate.

The work group is required to meet at least monthly beginning in July 2021 and is required to submit findings and recommendations to the Governor, the Legislative Research Commission, the Interim Joint Committee on Health and Welfare, and the Interim Joint Committee on Banking and Insurance by December 31, 2021. The work group is dissolved after December 31, 2021.

SB 5 – An Act Relating to Emergencies and Declaring an Emergency (Acts Ch. 205)

This Act provides liability protection to businesses, schools and organizations who reasonably attempted to follow executive orders and government guidelines related to COVID-19. The Act limits liability by altering the duties that owners (which includes tenants, occupants, and automobile operators, among others) are owed under tort law to invitees during the state of emergency. Owners do not "extend any assurance that the premises are safe from any risk of exposure to COVID-19," do not "owe a duty to protect from or warn about any risk related to or caused by COVID-19," and do not "assume responsibility, or incur liability, for any alleged injury, loss, or damage to persons or property arising from a COVID-19 claim."

The Act also:

- Affords liability protections for "essential services providers," including child care and health care providers; financial institutions; organizations that provide charitable and social services; individuals and businesses that produce, supply and prepare food; and elementary and secondary schools, whether public or private;
- Prescribes the statute of limitations for COVID-19 claims and the accrual of such claims. Moreover, the Act applies retroactively to March 2, 2020, the Governor's declaration of a state of emergency, and covers injury or harm incurred on or after that date until the declaration is lifted;
- Does not protect businesses or individuals that act with gross negligence, that engage in wanton, willful, malicious or intentional misconduct, or that disregard executive orders or governmental guidelines relating to COVID-19; and
- Deletes the sections waiving immunity for governmental entities to the extent that they maintain liability insurance or self-insurance.

Senate Bill 16 – An Act Relating to Colon Cancer Screening and Prevention and Making an Appropriation Therefor (Acts Ch. 130)

This Act makes various changes to the Colon Cancer Screening Program including changing the name of the program to the Colon Cancer Screening and Prevention Program, allowing funding through the sale of a special license plate, and amending the membership of the advisory committee to include the Commissioner of the Department of Insurance, or his or her designee and the commissioner of the Department for Medicaid Services, or his or her designee.

SB 71 – An Act Relating to Motor Vehicles (Acts Ch. 74)

This Act adopts minimum standards for towing vendor services for emergency towing, private property towing, storage of towed vehicles, and fees. The provisions are based on the NCOIL Model Towing Act.

The Act requires:

- Towing companies to take photographs, video, or other visual documentation of the vehicle damages prior to the vehicle being removed from the tow truck;
- Towing companies to take all reasonable efforts to prevent further damage;
- Towing companies to maintain a record for two (2) years and to provide the records for inspection to an insurance company or an involved individual if the vehicle was involved in a collision;
- Towing companies and storage facilities to provide a rate sheet at their place of business and to an owner that is present at the scene of a disabled vehicle;
- Notice be provided within ten (10) days to an owner and lienholder of a towed vehicle;
- Any invoice be provided within 24 hours of a request from an insurer;
- A vehicle to be released to a representative of an insurance company upon payment of all costs incurred against a motor vehicle that is towed and stored; and
- Storage facilities to be accessible during posted business hours and to provide a phone number for calls during and outside business hours.

The Act prohibits:

- Towing companies from stopping at a scene unsolicited for emergency towing services; and
- For emergency tows, rates being charged in excess of the rate sheet

Senate Bill 215 – An Act Relating to Transportation (Acts Ch. 186)

This Act includes, in part, the creation of new statutes in KRS Chapter 189 to allow the legislative body of certain local governments to establish a pilot program to authorize and regulate the operation of an off-highway vehicle (OHV) on a public roadway. Under an OHV ordinance, a person is permitted to operate an OHV on a public roadway if:

- The operator is eighteen (18) years of age or older;
- The operator has a valid operator's license in his or her possession;
- The OHV is insured by the owner or operator, for the payment of tort liabilities in the same form and amounts as set forth in KRS 304.39-110 for motorcycles;
- Proof of insurance is inside the OHV at all times of operation on a public roadway;
- The OHV is equipped with all safety equipment required under this section;
- The vehicle is being operated between one (1) hour before sunrise and one (1) hour after sunset, except for good cause;
- Any passenger under the age of sixteen (16) is wearing a helmet; and
- The operator and passengers are wearing eye protection if the OHV is not equipped with a windshield.

The person operating an OHV on a public roadway under an OHV ordinance is subject to the same traffic regulations as a motor vehicle. However, the OHV is not considered to be a motor vehicle and is exempt from vehicle regulation and emissions compliance certificate requirements.

The Act specifically states that it does not require an insurance company to provide OHV insurance coverage.

Senate Bill 251 – An Act Relating to the Department of Law (Acts Ch. 173)

This Act allows the Attorney General's office venue flexibility to challenge the constitutionality of any statute, executive order, administrative regulation, or order of a program, cabinet, or department. The Act also allows majority leadership would also have the authority to direct the AG's involvement in legal actions.