COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, Kentucky

BULLETIN 2023-03

INSURANCE LEGISLATION ADOPTED BY THE 2023 KENTUCKY GENERAL ASSEMBLY (REGULAR SESSION)

THIS BULLETIN IS FOR INFORMATIONAL 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 2023 ACTS OF THE KENTUCKY GENERAL ASSEMBLY ARE PUBLISHED IN THE SUMMER OF 2023. UNLESS OTHERWISE NOTED, THE EFFECTIVE DATE OF LEGISLATION IS JUNE 29, 2023. THIS BULLETIN IS NOT A COMPREHENSIVE REVIEW OF EACH ACT, BUT RATHER, SUMMARIZES THE MAIN PROVISIONS OF EACH ACT.

(Bills as enacted are available on the LRC website at https://legislature.ky.gov/Pages/index.aspx.)

House Bill 148- An Act Relating to Assignment of Substance Abuse or Mental Health Treatment Benefits (Acts Ch. 86)

This Act creates a new section of KRS Chapter 304, Subtitle 17A, related to the assignment of substance abuse and mental health treatment claims.

Section 1 of the Act applies to health insurance policies as defined in KRS 304.17A-500. Pursuant to certain conditions being met, an insurer or its agency cannot prohibit or restrict an insured from making a written assignment of substance abuse benefits or mental health treatment benefits to a facility providing such services.

The insurer or its agent may require the facility to:

- Prior to providing a service, furnish the insured with a statement that the facility is an out-of-network provider, and that facility may charge the insured for services not covered under the insurance contract and may balance bill the insured;
- Provide the insured a schedule of all applicable charges the facility may charge for services to the insured, the terms of payment that may apply, and whether interest will be charged for unpaid services;
- Submit claims associated with the benefits provided within ninety (90) days of providing the service;
- Maintain records of claims associated with the benefits;
- Respond to any inquiry from the insurer's fraud investigation unit established under KRS 304.47-080; and

- Make a good faith effort to abide by the standards of care of the American Society of Addiction Medicine, the American Association for Community Psychiatry Level of Care Utilization System, or the American Association for Community Psychiatry's and the American Academy of Child and Adolescent Level of Care/Service Intensity Utilization System.

An assignment made by an insured is valid as of the effective date contained in the assignment. The assignment remains in effect until the date the insured is discharged from the facility, or the date the facility receives written notice of the termination, whichever is earlier.

Upon notice of the assignment, the insurer shall make payments directly to the substance abuse or mental health facility for all services rendered by the facility to the insured for the duration of the assignment.

In addition to health insurance policies defined under KRS 304.17A-500, the state employee health plan and any self-funded health plan offered by a post-secondary educational institution must also comply with the requirements of the Act.

The effective date of this Act is June 29, 2023, and it applies to health insurance policies issued, delivered, or renewed on or after that effective date.

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

House Bill 170- An Act Relating to Coverage for Medical Services (Acts Ch. 30)

This Act creates a new health coverage mandate for health benefit plans. Pursuant to Section 1 of the Act, health benefit plans will be required to provide coverage for oocyte and sperm preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility. The coverage shall include evaluation expenses, laboratory assessments, and medication and treatment associated with oocyte and sperm cryopreservation procedures, including obtaining, freezing, and storing gametes for up to a year.

This coverage may:

- Exclude costs associated with storage of oocyte or sperm after one (1) year;
- Include age restrictions in accordance with the guidelines of the American Society for Reproductive Medicine or the American Society of Clinical Oncology;
- Include a lifetime limit of one (1) oocyte or sperm cryopreservation procedure per eligible insured;
- Be limited to nonexperimental procedures, as defined by the American Society for Reproductive Medicine or the American Society of Clinical Oncology.

If a health insurance policy provides coverage for orchiectomy as treatment for testicular or other urological cancer, Section 2 of the Act requires the coverage to be provided in a manner determined in consultation with the attending physician and insured. Moreover, the coverage is subject to applicable cost sharing requirements consistent with the cost sharing for all stages of surgical

reconstruction and complications related to the orchiectomy or orchidectomy, including testicular or other urological prostheses. The insurer is required to provide, upon enrollment and annually thereafter, written notice of the availability of orchiectomy or orchidectomy coverage. All health policies, including health benefit plans, fall subject to this requirement.

More specifically, the requirements of the Act are also applicable to limited health service benefit plans, the state employee health plan, and any self-funded health plan offered by a post-secondary educational institution.

The effective date of this Act is January 1, 2025, and it applies to policies issued or renewed on or after that effective date.

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

House Bill 180- An Act Relating to Coverage for Biomarker Testing (Acts Ch. 77)

This Act creates a new health coverage mandate for health benefit plans. If biomarker testing is supported by medical and scientific evidence, health benefit plans are required to provide coverage for the testing when ordered by a qualified health care provider for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition. "Biomarker" is defined as a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, and it expressly includes (but is not limited to) gene mutations and protein expression.

If the insurer restricts coverage for biomarker testing, the insurer and prescribing provider shall have access to a clear, readily accessible, and convenient exceptions process made available on the insurer's website. Any prior authorization requirement applicable to biomarker testing coverage shall comply with existing prior authorization law.

The requirements of this Act also apply to Medicaid and Medicaid Managed Care Organizations that provide Medicaid benefits.

The effective date of this Act is January 1, 2024, and it applies to all health benefit plans issued, amended, or renewed on or after that effective date.

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

House Bill 210- An Act Relating to the Kentucky Insurance Guaranty Association Act (Acts Ch. 19)

Section 1 of the Act amends KRS 304.36-030 by clarifying that the provisions of the Kentucky Insurance Guaranty Fund (KIGA) apply to health insurance written by an insolvent insurer if the insurer was not a member of the Kentucky Life and Health Insurance Guaranty Association.

Section 2 of the Act amends KRS 304.36-050 to include, as a covered claim by KIGA, an obligation assumed by an assuming insurer from a ceding insurer, when the assuming insurer becomes insolvent, if:

- At the time of the assuming insurer's insolvency, the ceding insurer is no longer admitted to transact business in Kentucky; and
- Both the assuming insurer and the ceding insurer were members of KIGA at the time the assumption was made.

The Act excludes from the definition of a covered claim, an insurance policy issued by a nonmember insurer and later allocated to, transferred to, assumed by, or otherwise made the sole responsibility of a member insured under a state statute commonly known as a "Division" or "Insurance Business Transfer" statute.

Additionally, the Act excludes as a covered claim any first party claim by an insured whose net worth exceeds ten million dollars ($10,000,000). The previous limit was an insured whose net worth exceeded twenty-five million dollars ($25,000,000).

The Act further excludes from KIGA coverage the following claims:

- An obligation incurred after the expiration date of the insurance policy;
- An obligation incurred after the insurance policy has been replaced by the insured, canceled at the insurer's request, or canceled by the receiver or liquidator;
- An obligation to a state, other than Kentucky, or the federal government; or
- Any claim for interest.

The Act amends the definition of insolvent insurer to require that the insolvent insurer be a member of KIGA at the time the policy is issued. Self-insurers are excluded from being considered a member, and are defined as:

- A person that covers its liabilities through a qualified individual or group self-insurance program or any formal program created for the specific purpose of covering liabilities typically covered by insurance; and
- Includes, but is not limited to, liability self-insurance group organized under KRS Chapter 304 Subtitle 48, workers' compensation self-insured groups organized under KRS Chapter 304 Subtitle 50, and self-insurers and self-insured groups under KRS Chapter 242.

Section 3 of the Act amends KRS 304.36-080. Pursuant to this amendment, KIGA will be required to pay an amount of up to five hundred thousand dollars ($500,000) per insured event for all covered claims resulting from that event for benefits arising from a cybersecurity policy.

The requirements of this Act are effective on June 29, 2023.

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

House Bill 232- An Act Relating to Insurance Adjusters (Acts Ch. 11)

This Act creates new requirements for public adjusters. Section 1 of the Act amends KRS 304.9-430 by raising the financial responsibility requirements for public adjusters. A public adjuster must provide and maintain a surety bond or letter of credit in the amount of fifty thousand dollars ($50,000).

Section 2 of the Act amends KRS 304.9-433, placing certain requirements on the contract executed between the public adjuster and the insured. As a general rule, a public adjuster shall not provide services to an insured until a contract has been executed on a form approved by the Department. Pursuant to the Act, the Commissioner may approve a contract form that allows a public adjuster to provide services to an insured before the contract is executed in emergency circumstances.

Any contract form filed for approval with the Department is subject to disapproval at any time if the contract: (1) is in violation of KRS Chapter 304; (2) contains, or incorporates by reference, inconsistent, ambiguous, or misleading clauses; or (3) contains any title, heading, or other indication of its provisions that is misleading or printed in a typeface size or manner of reproduction that is substantially illegible.

The Act further amends KRS 304.9-433 to require that the contract between the public adjuster and the insured include:

- A statement that the adjuster shall not give legal advice or act on behalf of any person in the negotiation or settling of a claim for bodily injury, death, or noneconomic damages;
- The process for rescinding the contract, including the date by which rescission of the contract by the public adjuster or insured may occur; and
- A statement that clearly states in substance the following: "Complaints regarding this contract or regarding the public adjuster may be filed with the Consumer Protection Division of the Kentucky Department of Insurance."

Within seventy-two (72) hours of entering into a contract with an insured, the public adjuster is required to provide the insurer with a copy of the executed contract. The insured has a three (3) day right to rescind a contract with a public adjuster.

Section 3 of the Act also creates new sections of KRS Chapter 304, Subtitle 9, that place additional requirements on public adjusters concerning their relationship with the insured. A public adjuster is required to give the insured written notice of the insured's rights enumerated in the Act. Additionally, the public adjuster shall ensure that:

- Prompt notice of the claim is provided to the insurer;
- The property subject to a claim is available for inspection of the loss or damage by the insurer; and
- The insurer is given the opportunity to interview the insured directly about the loss or damage claim.

A public adjuster shall not restrict or prevent the insurer, or someone representing the insurer, from: (1) having reasonable access at reasonable times to the insured or the insured property that is subject to the claim; (2) obtaining necessary information to investigate and respond to a claim; or (3) corresponding directly with the insured regarding the claim, except that the public adjuster shall be copied on any correspondence related to the claim.

Pursuant to the Act, a public adjuster shall not act in a manner that obstructs or prevents the insurer or its adjuster from timely conducting an inspection of the property that is the subject of the claim. The public adjuster may be present for the inspection of the property. If, after a reasonable request, the unavailability of the public adjuster would delay the timely inspection of the property, the insured must allow the insurer to have access to the property without the presence of the public adjuster.

The Act also imposes certain regulatory requirements related to the public adjuster's financial interests:

- The public adjuster must provide the insured, the insurer, and the Commissioner of the Department a written disclosure regarding any direct or indirect financial interest the public adjuster has with any party involved in the claim;
- The public adjuster shall not participate directly or indirectly in the reconstruction, repair, or restoration of property subject to the claim;
- The public adjuster shall not engage in any activity that may reasonably construed as a conflict of interest, including directly or indirectly soliciting or accepting any remuneration of any kind or nature;
- The public adjuster may not have a financial interest in any salvage, repair, or any other business entity that obtains business in connection with any claim the adjuster has a contract to adjust; and
- The public adjuster shall not use claim information obtained in the course of a claim investigation for commercial purposes.

Section 4 of the Act places certain duties on public adjusters concerning funds received or held by the public adjuster. All funds received or held by a public adjuster on behalf of the insured toward the settlement of a claim must be handled in a fiduciary capacity and deposited in one or more separate noninterest bearing trust accounts. These funds shall: (1) be held separately from personal or nonbusiness funds; (2) not be comingled or combined with other funds; (3) be reasonably ascertainable from the records of the public adjuster; and (4) be disbursed within thirty (30) calendar days of any invoice received by the public adjuster, upon approval from the insured that the work has been satisfactorily completed.

Section 5 of the Act mandates requirements related to the fee charged by a public adjuster. Any fee charged by a public adjuster shall be based solely on the amount of insurance settlement proceeds actually received by the insured and collected by the public adjuster after the insured has received the settlement proceeds. The public adjuster may charge a commission for services through an hourly fee, a flat rate, a percentage of the total amount paid by the insurer, or another method of compensation.

The fee charged by the public adjuster shall not be unreasonable. The public adjuster may charge a reasonable fee that does not exceed fifteen percent (15%) of the total amount paid by the insurer for a non-catastrophic claim, and ten percent (10%) of the total amount paid by the insurer for a catastrophic claim.

If, within seventy-two (72) hours after the date of a loss or damage is reported to the insurer, the insurer pays or commits to pay the policy limits, the public adjuster shall: (1) not receive a commission consisting of a percentage of the total claim; (2) inform the insured that the claim settlement amount may not be increased by the insurer; and (3) be entitled only to reasonable compensation for the services provided based on the time spent working on the claim, including expenses.

Finally, Section 6 of the Act sets forth penalties that may be imposed on public adjusters for engaging in certain enumerated acts. The Department may deny, suspend, or revoke the license of a public adjuster, or apprentice public adjuster, and may impose a fine up to five thousand dollars ($5,000.00) per violation, should the public adjuster or apprentice adjuster engage in any of the following acts:

- Violation of any provisions of the KRS Chapter 304, including this Act;
- Violation of any regulation promulgated pursuant to KRS Chapter 304;
- Violation of any Order issued by the Commissioner or the Department;
- Receipt of payment or anything of value as the result of a deceptive or unfair practice;
- Receipt or acceptance of a fee, kickback, or other thing of value pursuant to any agreement or understanding, oral or otherwise, from anyone other than the insured;
- Entry into a split-fee arrangement with another person who is not a public adjuster; or
- Acceptance of payment for public adjuster services that have not been performed.

The requirements of this Act are effective on June 29, 2023.

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

House Bill 264- An Act Relating to Regulatory Relief (Acts Ch. 122)

This Act creates a framework that enables a person to introduce, on a limited access basis, an innovative business offering in Kentucky without having to obtain a license or other authorization.

Section 2 of the Act creates a new section of KRS Chapter 15. Pursuant to this Section, the General Regulatory Sandbox Advisory Committee (Committee) is established. The Committee is administratively attached to the Kentucky Attorney General's Office. The Committee is to advise and make recommendations to the Kentucky Office of Regulatory Relief concerning the implementation and administration of the General Regulatory Sandbox Program. The Committee will consist of fourteen (14) members appointed from the following lists:

Five (5) members representing the business community appointed by the Attorney General. These appointees are appointed from a list of three nominees from the following organizations: Kentucky Chamber of Commerce; Kentucky Association of Manufacturers; National Federation of

Independent Business; Kentucky Retail Federation; and Kentucky Farm Bureau. Five (5) members consisting of the Cabinet Secretary, or his or her designee, from the following Cabinets: Transportation Cabinet; Energy and Environmental Cabinet; Cabinet for Economic Development; Public Protection Cabinet; and Education and Labor Cabinet. One (1) member of the Senate appointed by the President of the Senate, and one (1) member of the Senate appointed by the Minority Floor Leader. One (1) member of the House of Representatives appointed by the Speaker of the House, and one (1) member of the House of Representatives appointed by the Minority Floor Leader.

Section 3 of the Act establishes the Kentucky Office of Regulatory Relief (KORR) within the Kentucky Attorney General's Office. KORR shall:

- Administer the regulatory sandbox;
- Establish a program to enable a person to obtain legal protections and limited access to the market in Kentucky to demonstrate an innovative offering without obtaining a license or other authorization that might be required;
- Establish an application fee not to exceed one thousand dollars ($1,000.00) for admission into the regulatory sandbox;
- Act as a liaison between private businesses and applicable agencies to identify administrative regulations that may be waived or suspended under the regulatory sandbox;
- Consult with each applicable agency; and
- Administer the provisions of the Act.

KORR may:

- Review administrative regulations that may unnecessarily inhibit the creation and success of new companies or industries, and recommend modification of those regulations to the Governor and General Assembly;
- Create a framework to analyze the risk to the health, safety, and financial well-being of consumers by removing or temporarily suspending administrative regulations inhibiting the creation or success of new and existing companies or industries;
- Propose reciprocity agreements between states that use or propose to use similar regulatory sandbox programs;
- Enter into agreements with or adopt the best practices of corresponding federal regulatory agencies or other states that may administer similar regulatory sandbox programs;
- Consult with businesses in Kentucky about existing or potential proposals for the regulatory sandbox; and
- Promulgate necessary administrative regulations to administer the regulatory sandbox.

Section 4 of the Act creates the General Regulatory Sandbox Program within KORR. An applicant for the regulatory sandbox shall submit to KORR the following:

- The required application fee;

- A written application on a form prescribed by the KORR that: (1) confirms the applicant is subject to Kentucky jurisdiction; (2) confirms the applicant has established a physical or virtual location in Kentucky where the program will be developed and performed, and where the records are kept; (3) contains relevant contact information for the applicant; (4) discloses any criminal convictions of the applicant and participating personnel; (5) contains a description of the innovation, including certain enumerated statements; and (6) lists each governmental agency known to regulate the applicant.
- Any other information required by KORR.

Section 4 of the Act also states that a person is not eligible to make an application to KORR if that person is seeking regulatory relief available under KRS 304.3-700 to 304.3-735, which set out the requirements of the Kentucky Insurance Code sandbox.

Section 5 of the Act describes the duties KORR must perform upon receipt of a sandbox application. These duties include consulting with each governmental agency that regulates the applicant's business and seeking additional necessary information. No later than five (5) business days after receipt of a completed application, KORR shall refer the application to each governmental agency that regulates the applicant's business.

Section 6 of the Act requires an agency that receives a sandbox application to provide a written report to KORR within thirty (30) days. This report shall describe any likely harm to the health, safety, or financial well-being of consumers that the applicable administrative regulation for which a waiver is sought protects against. The report shall also make a recommendation to KORR regarding the admittance of the applicant to the regulatory sandbox. If the agency fails to remit a report, KORR shall assume the agency does not object to the sandbox application. Upon receipt of the agency report, KORR refers the application to the Committee. The Committee is to review the application and make a recommendation to KORR regarding acceptance of the application into the regulatory sandbox.

KORR then reviews the application, in consultation with each applicable agency and the Committee, to consider final approval of the application. Pursuant to this final review, KORR shall consider whether:

- The applicant's plan adequately protects consumers from potential harm identified by any applicable agency;
- The risk of harm to consumers is outweighed by the potential benefits to consumers by approving the application; and
- Certain administrative regulations that regulate an offering shall not be waived or suspended even if the applicant is approved as a sandbox participant.

An applicant becomes a sandbox participant if KORR approves the application and enters into a written agreement with the applicant describing the specific administrative regulations that are waived or suspended.

Section 7 of the Act permits KORR to deny a regulatory sandbox application if the applicant, or any person participating in the application, has been convicted, entered a plea of *nolo contendere*,

or entered a plea of guilty or *nolo contendere* held in abeyance for any crime involving significant theft, fraud, or dishonesty. However, the crime must bear a significant relationship to the applicant's ability to safely and competently participate in the regulatory sandbox.

Section 8 of the Act provides that, once an application is approved for the regulatory sandbox, the applicant has twelve (12) months to demonstrate the innovation in the market. This Section goes on to put in place the parameters to be complied with during the demonstration.

Section 12 of the Act amends KRS 304.3-705 to say that a person regulated under KRS Chapter 304 may participate in the Act's regulatory sandbox if: (1) the person is not authorized to make an application under the Kentucky Insurance Code sandbox; (2) or the person is seeking regulatory relief not available under the Kentucky Insurance Code sandbox

The requirements of this Act are effective on March 15, 2024.

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

House Bill 345- An Act Relating to Medicare Supplement Insurance (Acts Ch. 182)

This Act creates new requirements for Medicare supplement policies. A new section of KRS 304.14-500 to 304.14-550 is created to prohibit an insurer issuing a Medicare supplement policy from denying, conditioning the issuance of, or discriminating in the pricing of a policy because of health status, claims experience, receipt of health care, or medical condition to the following applicants:

1. An applicant that submits an application prior to or during the six (6) month period beginning on the first day of the first month in which the applicant is sixty-five or older and timely enrolled for benefits under Medicare Part B, without penalty under federal law;

2. An applicant that is non-age eligible for Medicare and:
   a) submits an application prior to or during the six (6) month period beginning on the first day of the first month in which the non-age eligible person is enrolled in Medicare Part B; or
   b) the applicant was enrolled for benefits under Medicare Part B prior to the effective date of this Act and either submits an application for the Medicare supplement policy during the six (6) period beginning on the effective date of this Act or, if an application is not available, the applicant requests an application during the six (6) period beginning on the effective date of this Act; or

3. The applicant is: (a) insured under a Medicare supplement policy at the time of application; (b) the application is submitted to a different Medicare supplement insurer within sixty (60) days of the applicant's birthday; and (c) the applicant is seeking to maintain the same Medicare supplement plan.

A Medicare supplement policy issued to a non-age eligible applicant pursuant to the provisions of the Act shall not charge the applicant more than the weighted average age premium rate for the

policy and shall not contain any waiting period or pre-existing condition limitation or exclusion. The Act sets forth a formula for calculating the weighted average aged premium rate using the rates calculated for Medicare supplement policies issued to Medicare eligible individuals who are sixty-five (65) and older.

The requirements of this Act are effective on January 1, 2024.

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

Senate Bill 209- An Act Relating to Health Care (Acts Ch. 130)

This Act amends KRS 304.17A-164, relating to cost sharing limitations for prescription drugs provided under a health benefit plan. For high deductible insurance plans with health savings accounts (HRAs), current IRS Rules exempt from taxation monies placed in the HRAs. This tax exemption is only allowed if the individual utilizing such a plan first meets the policy's high deductible.

Currently, KRS 304.17A-164(2)(b) prohibits an insurer or pharmacy benefit manager from excluding any cost-sharing amounts paid by an insured, or on behalf of an insurer by another person, when calculating the insured's contribution to any cost-sharing requirements. This Act clarifies that the prohibition of KRS 304.17A-164(2)(b) does not apply to a high deductible plan with an HSA, if doing so would disallow the tax-exempt status of the HSA contributions under IRS Rules.

The requirements of this Act are effective on June 29, 2023.

Contact: *Health and Life Division,*
(502) 564-6088