COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
Frankfort, Kentucky

BULLETIN 2022-001

INSURANCE LEGISLATION ADOPTED BY THE 2022 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 2022 ACTS OF THE KENTUCKY GENERAL ASSEMBLY ARE PUBLISHED IN THE SUMMER OF 2022, UNLESS OTHERWISE NOTED, THE EFFECTIVE DATE OF LEGISLATION IS JULY 14, 2022. THE 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 here)

House Bill 91- An Act Relating to the Issuance and Renewal of Occupational Licenses to Military Spouses (Acts Ch. 107)

This Act amends KRS 12.357 to require an administrative agency to issue a temporary or regular license to the spouse of a current member of the Armed Forces of the United States, without requiring the payment of any dues or fees if the spouse meets licensing requirements and satisfies the proof requirements of KRS 12.357(2)(a)-(c). Previously, the statute only required issuance of the temporary or regular license to the spouse of an active-duty member of the Armed Forces, but the fees and dues were not waived.

The Act also requires an administrative agency to issue or renew any regular occupational license for the spouse of a current member of the Armed Forces of the United States, so long as the spouse meets the statutory requirements for the occupational license. If the administrative agency requires electronic payment of the occupational license fee prior to issuance, the fee must be refunded within 30 days if the spouse satisfies the proof requirements of KRS 12.357(2)(a)-(c).

The requirements of this Act are effective on July 14, 2022.

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

House Bill 171- An Act Relating to Delinquency Proceedings Involving Insurer-members of Federal Home Loan Banks (Acts Ch. 61)

This Act creates a new section of KRS Chapter 304 Subtitle 33, the Kentucky insurance code provisions that set forth insurer rehabilitation and liquidation procedures. The federal home loan bank (FHLB) is an institution charted under the Federal Home Loan Bank Act of 1932, 12 U.S.C.

sec. 1421 et seq. The FHLB loans money to its member institutions, which include banks and insurers.

If an insurer-member goes into rehabilitation or liquidation, the new code provisions provide that the FHLB shall not be stayed or prohibited from exercising its rights regarding pledged collateral by an insurer-member for more than ten (10) days following the date of a temporary restraining order, preliminary injunction, or permanent injunction issued by a court. If the FHLB exercises its rights regarding the pledged collateral, the FHLB shall, within seven (7) days of receiving a redemption request from the insurer-member, repurchase any the insurer-member's outstanding capital stock in excess of the amount the insurer-member must hold as a minimum investment in the FHLB.

No later than ten (10) days after the appointment of a receiver in a receivership or liquidation proceeding, the FHLB shall provide the receiver with a process and timeline for the following:

- The release of collateral held by the FHLB that exceeds the amount required to support the secured obligation;
- The release of any collateral of the insurer-member remaining in the FHLB's possession once all outstanding secured obligations of the insurer-member have been repaid in full;
- The payment of fees owed by the insurer-member and the operation, maintenance, closure, or disposition of deposits and other insurer-member accounts, as mutually agreed upon by the receiver and the FHLB; and
- Any redemption or repurchase of FHLB stock or excess stock of any class that the insurer-member is required to own under agreements between the insurer-member an the FHLB

The appointed receiver of an insurer-member can request that the FHLB provide any available options for the insurer-member to renew or restructure a loan after the FHLB considers the market conditions, the terms of any outstanding loans, the applicable policies of the FHLB, and any federal laws or regulations applicable to the FHLB.

The new code provisions also exempt FHLB loans to insurer-members with regard to stays of pending litigation; the disavowing, rejection; or repudiation of a FHLB loan; fraudulent loan transfer provisions; and invalidation of preference provisions under KRS Chapter 304 Subtitle 33.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 188- An Act Relating to Telehealth (Acts Ch. 68)

This Act amends KRS 211.336 to prevent a state agency that promulgates regulations relating to telehealth from promulgating a regulation:

- Prohibiting the delivery of telehealth services by a credentialed Kentucky provider to a permanent Kentucky resident who is temporarily located outside of Kentucky;
- Prohibiting the delivery of telehealth services to a non-permanent resident of Kentucky by a provider credentialed in the person's home state; or
- Requiring a provider to be physically located in the state where he or she is credentialed to provide telehealth services to a person who is a permanent resident of the same state.

Section 2 of the Act requires the Cabinet for Health and Family Services to promulgate administrative regulations adding a definition for "temporarily located" to the glossary of telehealth terminology.

KRS 304.17A-138 presently requires that health benefit plans' telehealth coverage and reimbursement be equivalent to in-person coverage and reimbursement. Section 4 of the act amends KRS 304.7A-138 by adding a definition for "equivalent."

Section 3 of the Act applies this definition of "equivalent" to Medicaid telehealth services.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 219- An Act Relating to Lung Cancer Screening (Acts Ch. 71)

This Act establishes the Lung Cancer Screening Program within the Cabinet for Health and Family Services, Department for Public Health for the purpose of increasing lung cancer screening, reducing morbidity and mortality rates from lung cancer, and reducing the cost of treating lung cancer.

The Act also creates the Kentucky Lung Cancer Screening Program fund, which will be funded by general fund dollars and extra fees associated with special lung cancer license plates issued by the Transportation Cabinet.

Finally, the Act creates the Lung Cancer Screening Advisory Council, of which the Commissioner or her designee is a member, that will review best practices for screening, provide oversight of screening, and provide an annual report on outcomes from the program to LRC.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 307- An Act Relating to Liability and Workers' Compensation Self-Insurance Group Investments (Acts Ch. 62)

This Act makes amendments to KRS Chapter 304 Subtitle 48 and KRS Chapter 304 Subtitle 50 to expand the type of assets a liability self-insured group and a workers' compensation self-insured group can invest in using their respective funds.

The Act amends KRS 304.48-090(2)(b) to permit a liability self-insurance group to invest its funds in tax exempt and taxable obligations issued by any state or any of its agencies, counties, cities, municipalities, districts, political subdivisions, or other legal authorities within the United States that have a minimum rating of "BBB" by any nationally recognized statistical rating organization.

No less than 50% of the investments in such tax exempt and taxable obligations shall be in the Commonwealth, its agencies, or a county, city, district, municipality, political subdivision, or other legal authority within the Commonwealth.

KRS 304.48-090 is further amended to permit a liability self-insurance group to invest its funds in asset-backed securities if:

- The bond is issued, assumed, or guaranteed by a solvent institution created or existing under the laws of the United States, or a state, province, or territory of the United States;
- The asset-backed security investments do not exceed 10% of the total market value of the investment portfolio reflected in the most recent quarterly or annual statement of financial condition on file the commissioner; and
- The bond has a minimum rating of "BBB" by any nationally recognized statistical rating organization.

The Act also provides that if the asset-backed security investment is downgraded below "BBB," the liability self-insurance group shall divest itself of that investment as prudently as possible without incurring unnecessary losses.

The Act amends KRS 304.50-055(7)(b) to permit a workers' compensation self-insurance group to invest its funds in tax exempt and taxable obligations issued by any state or any of its agencies, counties, cities, municipalities, districts, political subdivisions, or other legal authorities within the United States that have a minimum rating of "BBB" by any nationally recognized statistical rating organization.

No less than 50% of the investments in such tax exempt and taxable obligations shall be in the Commonwealth, its agencies, or a county, city, district, municipality, political subdivision, or other legal authority within the Commonwealth.

KRS 304.50-055 is further amended to permit a workers' compensation self-insured group to invest its funds in asset-backed securities if:

- The bond is issued, assumed, or guaranteed by a solvent institution created or existing under the laws of the United States, or a state, province, or territory of the United States;

- The asset-backed security investments do not exceed 10% of the total market value of the investment portfolio reflected in the most recent quarterly or annual statement of financial condition on file the commissioner; and
- The bond has a minimum rating of "BBB" by any nationally recognized statistical rating organization.

The Act also provides that if the asset-backed security investment is downgraded below "BBB," the workers' compensation self-insurance group shall divest itself of that investment as prudently as possible without incurring unnecessary losses.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 317- An Act Relating to the Payment of Insurance Premiums and Cost Sharing on Behalf of an Insured (Acts Ch. 49)

Senate Bill 44 from the 2021 regular legislative session created a new statute in KRS Chapter 304, Subtitle 17A that requires 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.

HB 317 amends KRS 304.17A-255(2)(c) to say that, in addition to the present requirements, if the organization is not a church or convention or association of churches as defined by federal law, it must also meet at least one of the following requirements:

- The organization cannot receive any funding from a health care provider, as defined in KRS 304.17A-005;
- Any premium assistance offered by the organization must be sufficient to cover the insured's premium for a full plan year; or
- The organization has been issued an advisory opinion pursuant to 42 U.S.C. sec. 1320a-7d(b).

The Act also defines "plan year" by how it is defined in the health benefit plan. If the health benefit plan does not define "plan year" then it is designated as: 1) the deductible or limit year used under the plan; 2) if there is no deductible or limit year, it is the policy year; 3) if the previous two do not apply, then it is determined by the employer's or sponsor's taxable year; 4) if none of the previous apply, then it is the calendar year.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 350- An Act Relating to Insurance Regulatory Requirements (Acts Ch. 133)

This Act is the Department's financial accreditation bill. The provisions within this bill ensure that the Department meets the national accreditation standards set by the National Association of Insurance Commissioners (NAIC).

The Act amends KRS 304.3-240 and 304.2-205 to expressly provide for use of the NAIC annual statement blank and electronic filing of that blank for insurers authorized to do business in Kentucky.

The Act also amends various provisions in KRS Chapter 304 Subtitle 37 that reflect the changes in the NAIC model law to the group capital calculations for insurance holding companies and liquidity stress test requirements for certain sized life insurers.

The Act contains a sunset provision for provider-sponsored integrated health delivery networks. KRS 304.17A-300 was amended to say that after the effective date of the Act, no new provider-sponsored integrated health delivery networks will be licensed.

Finally, the Act amends KRS 304.38-070 to allow a provider-sponsored integrated health delivery network converting its certificate of authority to a health maintenance organization to have an initial net worth of one million five hundred thousand dollars. Thereafter, the entity shall maintain a minimum net worth equal to the greater of one million five hundred thousand dollars or four percent of the first one hundred and fifty million of annual revenue and one and one-half percent of the annual premium in excess of one hundred and fifty million dollars.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 370- An Act Relating to Health Care Trade Practice (Acts Ch. 48)

This Act creates a new section KRS Chapter 304 Subtitle 17C related to limited dental health services plans.

This Act sets forth the prior authorization parameters for any limited health service dental plan and requires transparency from the insurer to the dental provider regarding contracts, fees, claims, and payments. The dental benefit plan cannot deny any claim subsequently submitted for procedures included in a prior authorization, except under certain situations. Those circumstances include when another payor is responsible for the payment, the dentist has already been paid for the procedures, the service is not considered medically necessary or does not meet other terms and conditions under the plan, or there is fraud or misrepresentation.

Additionally, a dental plan can grant a third party access to its provider network if the provider is allowed to opt out of participation with the third party, the provider network contract has certain

provisions such as notification that third parties may be granted access to the network, the third party accessing the network agrees to abide by all contract provisions, and the plan identifies all third parties currently accessing its network on its website.

Finally, the Act requires a plan to notify the provider if there are any fees associated with a particular form of payment, and to provide the available methods of payments with instruction on how to select alternative methods. It also prohibits a plan from making credit cards the only form of payment. This bill amends KRS 304.17C-085 by prohibiting a provider from charging more for services and materials that are noncovered by the plan than the provider's usual and customary rate for those services and materials.

The requirements of this Act are effective on July 14, 2022.

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

House Bill 380- An Act Relating to Insurance Trade Practices (Acts Ch. 64)

In Section 1, this Act creates a new section of KRS Chapter 304 Subtitle 12 to allow an insurer or insurance producer to offer gifts of up to $250.00 in connection with the marketing, purchasing, or renewal of insurance, as long as the gift is not in the form of cash and the receipt of the gift is not contingent upon the purchase or renewal of insurance.

An insurer or insurance producer may also conduct sweepstakes or drawings in connection with the marketing, purchasing, or renewal of insurance as long as the following conditions are met:

- there is no participation cost to entrants;
- either the prizes do not exceed $500.00 in value, or the combined value of all prizes divided by the number of entrants is less than $10.00; and
- the sweepstakes or drawings do not obligate entrants to purchase or renew insurance.

Insurers or insurance producers may offer or provide products that relate to, or are offered in conjunction with, an insurance policy free of charge or at a discounted price as long as the products or services:

- Are primarily intended to educate the insured about, access, monitor, control, mitigate, or prevent risk of loss to persons, their lives, health, property, or other insurable interests; or
- Have a connection to, or enhance the value of, the insurance benefits.

Section 1 of the Act also exempts charitable contributions made by an insurer or insurance producer from the above limitations unless contributions are made in connection with the purchase or renewal of insurance.

Section 2 of the Act amends KRS 304.12-110 by removing the $25.00 prize, goods, wares, merchandise, or property exemption allowance from the definition of illegal inducement in accordance with the above revised limitations.

Section 3 of the Act amends KRS 304.12-100 by exempting charitable contributions made by an insurer or insurance producer from being considered a rebate or illegal inducement, unless those contributions are made in connection with the purchase or renewal of insurance.

The requirements of this Act are effective on July 14, 2022.

Contact: Consumer Protection Division
(502) 564-6034

House Bill 474- An Act Relating to Insurance Data Security (Acts Ch. 149)

This is the Department's data security bill. This Act provides three main requirements that licensees must have in place.

Section 4 of the Act requires that the licensee develop a security program to protect customers' non-public information from being breached. Each licensee develops the security program based on a risk assessment that the licensee performs on itself. The security program must be based on the size and complexity of the licensee and the nature and scope of the licensee's activities, including its use of third-party service providers.

Section 5 of the Act requires a licensee to perform an investigation if the licensee believes a cybersecurity event has occurred or may have occurred. The Act sets out the parameters on how the licensee is to conduct this investigation.

Finally, Section 6 of the Act contains a notice requirement when a cybersecurity event has occurred. Each licensee must notify the commissioner of a cybersecurity event involving nonpublic information in the licensee's possession as promptly as possible, but in no event later than three (3) business days from a determination that a cybersecurity event has occurred. This notice is submitted electronically, and the bill describes what the notice must contain. The Department will develop a form for the electronic filing of the notice of a cybersecurity event.

Certain entities are exempted from some of the requirements of the Act. For example, a licensee with fewer than 50 employees is not subject to the requirements of the Act. A licensee that has a HIPAA-compliant or Graham Leach Bliley-compliant security program is not subject to the requirement to develop a security program and is not subject the investigation requirements of Section 5. However, these entities must annually certify to the Department that they are compliant with HIPAA or Graham Leach Bliley.

The requirements of this Act are effective on January 1, 2023. Licensees have one year from this effective date to implement subsections (1) to (3) and subsections (5) to (7) of Section 4 of the Act. Licensees have two years to implement Section 4(4) of the Act.

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

Senate Bill 124- An Act Relating to Transportation and Declaring an Emergency (Acts Ch. 153)

The main provisions of this Act establish parameters for peer-to-peer car sharing program liability and insurance requirements. A peer-to-peer car sharing program is defined as a business platform that connects shared vehicle owners with shared vehicle drivers, enabling the shared vehicle driver use of the shared vehicle owner's auto for financial consideration.

In Section 8 of the Act, a new Section of KRS Chapter 365 is created providing that the peer-to-peer car sharing program (Program) assumes the liability of the shared vehicle owner for bodily injury and property damage to third parties during the car sharing period for at least the amounts required in KRS 304.39-110 for bodily injury and for basic reparation benefits found in KRS 304.39-020(2).

However, the Program does not assume the liability when the shared vehicle owner makes an intentional or fraudulent material misrepresentation or omission to the program before the car sharing period in which the accident occurs. The Program does not assume liability when the shared vehicle owner acts in concert with the shared vehicle driver who fails to return the shared vehicle pursuant to the terms of car sharing agreement.

The Program must ensure that, during the car sharing period, the vehicle owner and the shared vehicle driver are covered under a policy that provides at least the minimum coverage of KRS 304.39-110, and the policy must recognize that the vehicle may be used in a peer-to-peer program or does not exclude the use of the vehicle in a peer-to-peer program.

Section 9 requires the Program to:

- Notify the vehicle owner that use of the vehicle in the program may violate the contract terms of any lienholder agreement;
- Verify that there are no unrepaired safety recalls; and
- Notify the vehicle owner of the requirement to remove a vehicle from the program after receiving a recall notice, until the safety recall is repaired.

The requirements of this Act are effective on January 1, 2023.

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

Senate Bill 140- An Act Relating to Step Therapy Protocols (Acts Ch. 19)

This Act requires any "health plan" to develop clinical review criteria that establishes step therapy drug protocols. The clinical review criteria must be based on clinical practice guidelines that recommend drugs be taken in specific sequence. The protocols must be developed by a multidisciplinary panel of experts. Insurers are required to make clinical review criteria available upon request and the review criteria must be posted on their website.

"Health plan" is defined broadly to seemingly encompass any plan that has a drug benefit with step therapy protocols. In addition, Medicaid, KCHIP, the State Employee Health Plan, and any

self-funded health plan offered by a post-secondary educational institution must comply with the requirements of the Act.

The Act also outlines the process the insurer and Pharmacy Benefit Manager (PBM) must have in place to allow for exceptions to the step therapy protocols. If an exception is denied, the denial can be appealed through the insurer's or PBM's internal review process. If the exception is denied in the internal review, the insured has the right to an external review similar to the one set out in KRS 304.17A-600 through KRS 304.17A-633.

An insurer or PBM must annually report to the Department of Insurance the following:

- The number of step therapy exception requests received;
- The type of health care providers or medical specialties of health care providers that submitted exception requests;
- The number of exceptions that were denied and approved, and the number that were initially denied, appealed, and then subsequently reversed on appeal; and
- The medical conditions for which insurers were granted exceptions due to the likelihood that the drug would cause an adverse reaction.

The Department will promulgate an administrative regulation setting forth the parameters for reporting this information that will incorporate by reference a document for the filing of this information by the insurer or PBM.

The requirements of this Act are effective on January 1, 2023.

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