AN ACT relating to the expansion of health insurance options within Kentucky.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔Section 1. KRS 304.17A-005 (Effective July 1, 2019) is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

(5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-

91(d)(3);

(6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(7) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(8)~~[(a)]~~ "Creditable coverage"***:***

(a) Means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;

9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or
11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program***; and*** ~~[.]~~

(b) ~~[This term]~~Does not include coverage consisting solely of coverage of excepted benefits as defined in~~[subsection (14) of]~~ this section;

(9) "Dependent" means any individual who is or may become eligible for coverage under the terms of an individual or group health benefit plan because of a relationship to a participant;

(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;

(11) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a

state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(12) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled;~~[or]~~

(c) Any entity ***or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. sec. 1001 et seq., to provide an employee welfare benefit plan under guidance issued by the United States Department of Labor prior to the issuance of 29 C.F.R. sec. 2510.3-5***~~[that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers]~~, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health

insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation***; and***

(d) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. sec. 1001 et seq., to provide an employee welfare benefit plan, whose members consist of employers or a group of employers that satisfy the requirements of 29 C.F.R. sec. 2510.3-5.

Except as provided in ***Section 2 of this Act and*** KRS 304.17A-200~~[, 304.17A.210,]~~ and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in~~[subsection (30) of]~~ this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, ***except***~~[provided]~~ that an employer-organized association~~[that is a bona fide association]~~ as defined ***under paragraph (c) or (d) of this***~~[in]~~ subsection~~[(5) of this section]~~ shall be treated as a large group under this subtitle;

(13) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(14) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile

liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the

employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(18) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

(19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(20) "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;
2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or
3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(22) "Health benefit plan"***:***

(a) Shall include~~[Means]~~ any***:***

1. Hospital or medical expense policy or certificate;

2. Nonprofit hospital, medical-surgical, and health service corporation contract or certificate;

3. Provider sponsored integrated health delivery network;

4. ~~[a]~~Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;

5. Self-insured governmental plan or church plan;

6. Health maintenance organization contract; or

7. ~~[any]~~Health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued

for delivery in Kentucky**;**~~[,]~~ and

(b) Does not include**:**

1. Policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement~~[policy]~~, long-term care, Medicare supplement, specified disease, ***or*** vision care**;**~~[,]~~

2. Coverage issued as a supplement to liability insurance**;**~~[,]~~

3. Insurance arising out of a workers' compensation or similar law**;**~~[,]~~

4. Automobile medical-payment insurance**;**~~[,]~~

5. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance**;**~~[,]~~

6. Short-term ***limited duration*** coverage**;**~~[,]~~

7. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure**;**~~[,]~~

8. Medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract**;**~~[, or]~~

9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code**;**~~[, or]~~

10. Limited health service benefit plans**;**~~[,]~~ or

11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199;

(23) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS Chapter 315, or home medical equipment and services provider as defined pursuant to KRS 309.402, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Advanced practice registered nurses licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(25) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(26) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association~~[, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws]~~;

(27) "Insurer" means any 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 authorized to transact health insurance business in Kentucky;

(28) "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the

principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(29) "Kentucky Access" has the meaning provided in KRS 304.17B-001~~[(17)]~~;

(30) "Large group" means:

(a) An employer with fifty-one (51) or more employees;

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) ***A fully-insured***~~[An]~~ employer-organized association ***as defined in subsection (12)(c) or (d) of this section*** that***:***

1. Covers at least fifty-one (51) employee members; and

2. Is registered with the department pursuant to administrative regulations promulgated by the commissioner~~[is a bona fide association as defined in subsection (5) of this section]~~;

(31) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(32) "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(33) "Participant" means any employee or former employee of an employer, or any

member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of the employer or members of the organization, or whose beneficiaries may be eligible to receive any benefit as established in Section 3(7) of ERISA;

(34) "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

(35) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(36) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(37) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(38) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(39) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(40) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(41) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the

plan year;

(42) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members;

(43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) "Telehealth":

(a) Means the delivery of health care-related services by a health care provider who is licensed in Kentucky to a patient or client through a face-to-face encounter with access to real-time interactive audio and video technology or store and forward services that are provided via asynchronous technologies as the standard practice of care where images are sent to a specialist for evaluation. The requirement for a face-to-face encounter shall be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the patient's or client's medical history prior to the telehealth encounter;

(b) Shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call; and

(c) Shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9.

➔Section 2. KRS 304.17A-0954 is amended to read as follows:

(1)~~[For purposes of this section:~~

~~(a) "Base premium rate" has the meaning provided in KRS 304.17A-005;~~

~~(b) "Employer" means a person engaged in a trade or business who has two (2) or more employees within the state in each of twenty (20) or more calendar weeks in the current or preceding calendar year;~~

~~(c) "Employer-organized association" means any of the following:~~

~~1. Any entity which was qualified by the commissioner as an eligible association prior to April 10, 1998, and which has actively marketed a health insurance program to its members after September 8, 1996, and which is not insurer-controlled;~~

~~2. An entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and which is not insurer-controlled; or~~

~~3. Any entity which is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation;~~

~~(d) "Index rate" has the meaning provided in KRS 304.17A-005.~~

~~(2)~~] Notwithstanding any other provision of this chapter, the amount or rate of premiums for an employer-organized association health plan may be determined, subject to the restrictions of subsection ***(2)***[~~(3)~~] of this section, based upon the experience or projected experience of the employer-organized associations whose employers obtain group coverage under the plan.[~~ Without the written consent of the employer-organized association filed with the commissioner, the index rate for the employer-organized association shall be calculated solely with respect to that employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.~~]

(2)[~~(3)~~] The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized ***association*** health insurance

plan ***issued to an employer-organized association as defined in subsection (12)(a) to (c) of Section 1 of this Act***:

(a) The premium rates charged during a rating period to members of the employer-organized association with similar characteristics for the same or similar coverage, or the premium rates that could be charged to a member of the employer-organized association under the rating system for that class of business, shall not vary from its own index rate by more than fifty percent (50%) of its own index rate; and

(b) The percentage increase in the premium rate charged to an employer member of an employer-organized association for a new rating period shall not exceed the sum of the following:

1. The percentage change in the new business premium rate for the employer-organized association measured from the first day of the prior rating period to the first day of the new rating period;

2. Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating period of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the member as determined from the insurer's rate manual; and

3. Any adjustment due to change in coverage or change in the case characteristics of the member as determined by the insurer's rate manual.

(c) ~~[(4)]~~ In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area.

(d) Unless the written consent of the employer-organized association is filed

with the department, the index rate for the employer-organized association shall be calculated solely with respect to that employer-organized association and shall not be tied to, linked to, or otherwise adversely affected by any other index rate used by the issuing insurer.

(3) ~~[(5)]~~ For the purpose of this section, a health insurance contract that utilizes a restricted provider network shall not be considered similar coverage to a health insurance contract that does not utilize a restricted provider network if utilization of the restricted provider network results in measurable differences in claims costs.

➔Section 3. KRS 304.17A-808 is amended to read as follows:

A proposed self-insured employer-organized association group shall file with the commissioner an application for a certificate of filing accompanied by a nonrefundable filing fee of ***five hundred dollars ($500)*** ~~[five dollars ($5)]~~. Each application for a certificate of filing shall be submitted to the commissioner upon a form prescribed by the commissioner and shall set forth or be accompanied by:

(1) The group's name, location of its principal office, date of organization, and identification of its fiscal year. The application shall also include the name and address of each member if known at the time of application. If this information is unknown, a description of the group to be solicited for membership shall be included;

(2) A copy of the articles of association or governance documents;

(3) A copy of agreements with the administrator and with any service company;

(4) A copy of the bylaws of the proposed group;

(5) Certification of the group's financial solvency as set forth in KRS 304.17A-812;

(6) Designation of the initial board of trustees and administrator;

(7) The address where books and records of the group will be maintained at all times; and

(8) A statement describing the self-insured employer-organized association which shall

include:

(a) The health services to be offered;

(b) The financial risks to be assumed;

(c) The initial geographic area to be served;

(d) Pro forma financial projections for the first three (3) years of operation, including the assumptions the projections are based upon;

(e) The sources of working capital and funding;

(f) A description of the persons to be covered by the self-insured employer-organized association;

(g) Any proposed reinsurance arrangements;

(h) Any proposed management, administrative, or cost-sharing arrangements; and

(i) A description of the self-insured employer-organized association's proposed method of marketing.

➔Section 4. KRS 304.17A-812 is amended to read as follows:

(1) This section applies to a group applying for and holding a certificate of filing as a self-insured employer-organized association group.

(2) To obtain and to maintain its certificate of filing, a self-insured employer-organized association group shall have sufficient financial strength to pay all public or professional liabilities covered by the group, including known claims and expenses and incurred but unreported claims and expenses.

(3) The commissioner shall require the following of a self-insured employer-organized association group:

(a) An actuarial certification by a member of the American Academy of Actuaries of the adequacy of the proposed rates funding arrangements of the group;

(b) Specific reinsurance ensuring the solvency of the funding arrangement;

(c) A demonstration of capital and surplus as follows:

1. Initial financial requirements. Every self-insured employer-organized

association shall demonstrate initial capital and surplus equal to the greater of:

a. Five hundred thousand dollars ($500,000);

b. Two percent (2%) of projected annual contribution revenues on the first one hundred fifty million dollars ($150,000,000) of contributions and one percent (1%) of projected annual contributions on the contributions in excess of one hundred fifty million dollars ($150,000,000); or

c. An amount equal to the sum of eight percent (8%) of projected annual health care expenditures except those paid on a capitated basis or managed hospital payment basis and four percent (4%) of projected annual hospital expenditures paid on a managed hospital payment basis***, except the initial capital and surplus shall be not required to exceed the deductibility limits provided under 26 U.S.C. secs. 419 and 419A, as amended***.

2. Continuing financial requirements. Every self-insured employer-organized association shall demonstrate ongoing capital and surplus equal to the greater of:

a. Five hundred thousand dollars ($500,000);

b. Two percent (2%) of annual contribution revenues, as reported on the most recent annual financial statement filed with the commissioner, on the first one hundred fifty million dollars ($150,000,000) of contributions and one percent (1%) of annual premiums on the contributions in excess of one hundred fifty million dollars ($150,000,000); or

c. An amount equal to the sum of eight percent (8%) of projected annual health care expenditures except those paid on a capitated

basis or managed hospital payment basis and four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis, as reported on the most recent financial statement filed with the commissioner***, except the continuing capital and surplus shall be not required to exceed the deductibility limits provided under 26 U.S.C. secs. 419 and 419A, as amended***; and

(d) A fidelity bond for the administrator and a fidelity bond for the service company in forms and amounts prescribed by the commissioner.

(4) The commissioner, if not satisfied with the financial strength of a self-insured employer-organized association group, may require any or all of the following of a self-insured employer-organized association group:

(a) Security in the form and amount prescribed by the commissioner as follows:

1. A surety bond issued by a corporate surety authorized to transact business in the Commonwealth of Kentucky; or

2. Any financial security endorsement issued as part of an acceptable excess insurance contract issued by an authorized insurer, which may be used to meet all or part of the security requirement.

The bond or financial security endorsement shall be solely for the benefit of the insured creditors to pay claims and associated expenses and shall be payable upon the failure of the group to pay professional or public liability claims the group is legally obligated to pay. The commissioner may establish and adjust the requirements for the amount of security based on differences among groups in their size, types of business, years in existence, or other relevant factors.

(b) Specific and aggregate excess insurance in a form and amount issued by an insurer acceptable to the commissioner.

➔Section 5. KRS 304.17A-834 is amended to read as follows:

Self-insured employer-organized association groups shall file with the commissioner their ***forms,*** rates, underwriting guidelines, evidence of coverage, and any changes therein. The filing shall be accompanied by a filing fee of five dollars ($5) per form filing.