

304.17A-200 Prohibition against establishing certain rules of eligibility in small group, large group, or association markets -- Limitation on premium -- Participation rules -- Effect of denial of coverage -- Disclosure.

- (1) An insurer that offers health benefit plan coverage in the small group, large group, or association market may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or the dependent of the individual:
 - (a) Health status;
 - (b) Medical condition, including both physical and mental illness;
 - (c) Claims experience;
 - (d) Receipt of health care;
 - (e) Medical history;
 - (f) Genetic information;
 - (g) Evidence of insurability, including conditions arising out of acts of domestic violence; and
 - (h) Disability.
- (2) An insurer that offers health benefit plan coverage in the small group, large group, or association market shall not require any individual to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or a dependent of the individual. Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.
- (3) Subject to subsections (4) to (7) of this section, each insurer that offers health benefit plan coverage in the small groups market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health benefit plan.
 - (a) Notwithstanding any other provision of this subsection, the insurer may establish group participation rules requiring a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of those eligible for enrollment.
 - (b) The terms and participation rules of the group health benefit plan shall be uniformly applicable to small employers in the small group market.
 - (c) This subsection shall not apply to health benefit plan coverage offered by an insurer if the coverage is made available in the small group market only through one (1) or more bona fide associations.
- (4) In the case of an insurer that offers health benefit plan coverage in the small group market through a network plan, the insurer may:

- (a) Limit the employers that may apply for coverage to those with individuals who live, work, or reside in the service area of the network plan; and
 - (b) Within the service area of the network plan, deny coverage to employers if the insurer has demonstrated to the executive director that:
 - 1. The network plan will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and
 - 2. The insurer is applying this denial uniformly to all employers.
- (5) An insurer, upon denying health benefit plan coverage in any service area in accordance with subsection (4) of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty (180) days after the date the coverage is denied.
- (6) An insurer may deny health benefit plan coverage in the small group market if the insurer has demonstrated to the executive director that:
- (a) The insurer does not have the financial reserves necessary to underwrite additional coverage; and
 - (b) The insurer is applying this denial uniformly to all employers in the small group market.
- (7) An insurer, upon denying health benefit plan coverage in connection with group health plans in accordance with subsection (6) of this section, shall not offer coverage in the small group market for a period of one hundred eighty (180) days after the date the coverage is denied or until the insurer has demonstrated to the executive director that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.
- (8) A health benefit plan issued as an individual policy to individual employees or their dependents through or with the permission of a small employer shall be issued on a guaranteed-issue basis to all full-time employees and shall comply with the pre-existing condition provisions of KRS 304.17A-220.
- (9) (a) In connection with the offering of any health benefit plan to a small employer, an insurer:
- 1. Shall make a reasonable disclosure to a small employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this subsection; and
 - 2. Upon request of a small employer, provide the information described in paragraph (b) of this subsection.
- (b) Subject to paragraph (c) of this subsection, with respect to an insurer offering a health benefit plan to a small employer, information described in this subsection is information concerning:
- 1. The provisions of the coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates;
 - 2. The provisions of the health benefit plan relating to renewability of coverage;

3. The provisions of the health benefit plan relating to any preexisting condition exclusion; and
 4. The benefits and premiums available under all health benefit plans for which the small employer is qualified.
- (c) Information described in paragraph (b) of this subsection shall be provided to a small employer in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform a small employer of his or her rights and obligations under the health benefit plan.
- (d) An insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

Effective: April 10, 1998

History:Created 1998 Ky. Acts ch. 496, sec. 2, effective April 10, 1998.

Legislative Research Commission Note (6/20/2005). 2005 Ky. Acts chs. 11, 85, 95, 97, 98, 99, 123, and 181 instruct the Reviser of Statutes to correct statutory references to agencies and officers whose names have been changed in 2005 legislation confirming the reorganization of the executive branch. Such a correction has been made in this section.