

for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

- (11) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.
- (12) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an insured with a high-cost condition shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the specific high-cost condition that is the basis for refusing to issue a policy, a description of the Guaranteed Acceptance Program, and the name and the telephone number of a contact person who can provide additional information about the Guaranteed Acceptance Program.
- (13) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.
- (14) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

HISTORY: 1998 c 496, § 7, eff. 4-10-98

**304.17A-260 Approval to reenter state for insurer that ceased doing business after July 15, 1995, and before April 10, 1998**

An insurer that, on or after July 15, 1995, until April 10, 1998, issued standard health benefit plans under KRS 304.17A-160 and then ceased doing business in Kentucky may apply to the commissioner on or after April 10, 1998, until January 1, 1999, for approval to reenter Kentucky, and if the commissioner grants approval the insurer may engage in the health insurance business notwithstanding the provisions of KRS 304.17A-110(1)(d) as it existed on the date the insurer ceased doing business in Kentucky.

HISTORY: 1998 c 496, § 8, eff. 4-10-98

**304.17A-270 Nondiscrimination against provider in geographic coverage area**

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

HISTORY: 1998 c 496, § 13, eff. 4-10-98

**304.17A-280 Additions to high-cost conditions list; hearing**

The commissioner may, by administrative regulation, add to the list of high-cost conditions provided in KRS 304.17A-005 other high-cost conditions based on diagnosis and severity. At the request of an insurer, the commissioner shall hold a hearing to determine whether or not a condition should be listed.

HISTORY: 1998 c 496, § 14, eff. 4-10-98

**304.17A-290 Prohibition against renewal of nonstate employees and small groups under KRS 18A.2251 or 18A.2281**

- (1) Coverage of an individual who is not a state employee or a small group which on April 10, 1998, is covered under KRS 18A.2251 or KRS 18A.2281 shall not be renewed after April 10, 1998.
- (2) The state employee health insurance fund established under KRS 18A.2281 shall be deemed an insurer as defined in KRS 304.17A-005 only for the coverage it provides to individuals not state employees or to small groups and only until such time as this coverage terminates in accordance with subsection (1) of this section.
- (3) The state employee health insurance fund established under KRS 18A.2281 shall be subject to assessments and reimbursements under KRS 304.17A-400 to 304.17A-480 only for the premium collected and the claims paid for individuals who are not state employees and the small groups which are covered by the fund.
- (4) Except as provided in this section, the state employee health insurance fund established under KRS 18A.2281 shall not be deemed an insurer for any other purpose in this chapter and, in no event, at any time more than twelve (12) months after April 10, 1998, shall it be deemed to be an insurer.

HISTORY: 1998 c 496, § 24, eff. 4-10-98

**304.17A-300 Provider-sponsored integrated health delivery network; qualifications; fees; network subject to provisions of other subtitles**

- (1) A provider-sponsored integrated health delivery network may be created by health care providers for the purpose of providing health care services.
- (2) No person shall in this Commonwealth be, act as, or hold itself out as a provider-sponsored integrated health delivery network unless it holds a certificate of filing from the commissioner. Each provider-sponsored integrated health delivery network that seeks to offer services shall first be certified by the department.
- (3) Notwithstanding subsection (2) of this section, a provider-sponsored integrated health delivery network