304.17A-0954 Definitions for section -- Premium rate guidelines for employer-organized association plans.

(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 (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.

(3) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized health insurance plan:

(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.

(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.

(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.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1214, effective July 15, 2010. -- Amended 2002 Ky. Acts ch. 351, sec. 16, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 476, sec. 27, effective January 1, 2001. -- Created 1998 Ky. Acts ch. 496, sec. 11, effective April 10, 1998.