CHAPTER 262

(HB 390)

AN ACT relating to health insurance.

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

SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 17 of this Act:

(1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in Sections 12, 13, and 14 of this Act;

(6) "Health benefit plan" means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or 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 does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, 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, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, 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 coverage

supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and for purposes of Sections 1 to 17 of this Act includes short-term coverage policies.

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under Sections 12, 13, and 14 of this Act. An independent review entity which is accredited by the National Commission on Quality Assurance, the American Accreditation Health Care Commission, or another nationally recognized accreditation organization as identified by the department shall be deemed certified by the department;

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance origination; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in Section 9 of this Act, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(11) "Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment;

(12) "Provider" shall have the same meaning as set forth in KRS 304.17A-005;

(13) "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria.

(14) "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review.

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person. "Retrospective review" does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(16) "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review.

(17) "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Sections 1 to 17 of this Act shall apply to any insurer that covers citizens of the Commonwealth under a health benefit plan. An insurer shall maintain written procedures for:

(1) Determining whether a requested service, treatment, drug, or device is covered under the terms of a covered person's health benefit plan;

(2) Making utilization review determinations; and

(3) Notifying covered persons, authorized persons, and providers acting on behalf of covered persons of its determinations.

SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Sections 1, 2, 3, 4, 5, 6, 7, and 8 of this Act set forth the requirements and procedures regarding utilization review and shall apply to:

(a) Any insurer or its private review agent that provides or performs utilization review in connection with a health benefit plan; and

(b) Any private review agent that performs utilization review functions on behalf of any person providing or administering health benefit plans.

(2) Where an insurer or its agent provides or performs utilization review, and in all instances where internal appeals as set forth in Section 9 of this Act, are involved, the insurer or its agent shall be responsible for:

(a) Monitoring all utilization reviews and internal appeals carried out by or on behalf of the insurer;

(b) Ensuring that all requirements of Sections 1 to 17 of this Act are met;

(c) Ensuring that all administrative regulations promulgated in accordance with Sections 5, 7, and 15 of this Act are complied with; and

(d) Ensuring that appropriate personnel have operational responsibility for the performance of the insurer's utilization review plan.

(3) A private review agent that operates solely under contract with the federal government for utilization review or patients eligible for hospital services under Title XVIII of the Social Security Act shall not be subject to the registration requirements set forth in Sections 4, 5, and 7 of this Act.

SECTION 4. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that only licensed physicians shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act Subtitle F sec. 261-264 and 45 C.F.R. sections 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Be available twenty-four (24) hours a day, seven (7) days a week to conduct:

1. Preadmission review of an emergency admission, if preauthorization is required for emergency admissions or use of an emergency room;

2. Preauthorization of weekend admissions to a hospital, or to review services delivered on the weekend or after normal business hours, if the covered person is subject to preauthorization on weekends or after normal business hours; and

3. Review of a patient's continued hospitalization, if a prior authorization will expire on a weekend;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with Section 5 of this Act; (h) Provide a utilization review decision:

1. Within twenty-four (24) hours of a request for:

a. Preadmission review of a hospital admission, unless additional information is needed;

b. Preauthorization of treatment when the covered person is already hospitalized; or

c. Retrospective review of an emergency hospital admission;

2. Within two (2) business days of a receipt of a request for preauthorization for a treatment, procedure, drug, or device;

3. Within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire; and

4. Within twenty (20) business days of the receipt of requested medical information when the insurer or private review agent has initiated a retrospective review;

(i) Provide written notice of review decisions to the covered person, authorized person, and providers. An insurer or agent that denies coverage or reduces payment for a treatment, procedure, drug, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment;

2. The name, state of licensure, medical license number, and the title of the reviewer making the decision;

3. A description of other alternative treatments, services, or supplies covered by the health benefit plan; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in Section 9 of this Act, stating, at a minimum, whether the appeal shall be in writing, time limitations, or schedules for filing appeals, and the name and phone number of a contact person who can provide additional information;

(j) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(k) Comply with its own policies and procedures on file with the department.

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in Section 9 of this Act. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective until thirty (30) days after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

SECTION 5. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The department shall promulgate emergency administrative regulations regarding utilization review and internal review, including the specification of information required of insurers and private review agents which shall, at a minimum, include:

(1) A utilization review plan that includes information utilized for conducting preadmission, admission, readmission review, preauthorization, continued stay authorization, and retrospective review that, for each type of review, includes:

(a) Utilization review policies and procedures to evaluate proposed or delivered medical services;

(b) Time frames for review;

(c) A written summary describing the review process and required forms;

(d) Documentation of qualifications of personnel who developed the specific utilization review procedures relating to specialty and subspecialty areas;

(e) Descriptions and names of review criteria upon which utilization review decisions are based; and

(f) Additional standards, if any, for the consideration of special circumstances.

(2) The type and qualifications of the personnel either employed or under contract to perform utilization review;

(3) Assurance that a toll-free line will be provided that covered persons, authorized persons, and providers may use to contact the insurer or private review agent;

(4) The policies and procedures to ensure that a representative of the insurer or private review agent shall be reasonably accessible to covered persons, authorized persons, and providers at least forty (40) hours per week during normal business hours;

(5) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(6) A copy of the materials designed to inform covered persons, authorized persons, and providers of the toll-free number and the requirements of the utilization review plan;

(7) A list of the entities for which the private review agent is performing utilization review in this state; and

(8) Evidence of compliance or the ability to comply with the requirements and procedures established regarding utilization review and the administrative regulations promulgated thereunder.

SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

A utilization review decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer or its designee for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider.

SECTION 7. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) The department shall, through the promulgation of emergency administrative regulations, develop a process:

(a) For the review of applications for registration of insurers or private review agents seeking to conduct utilization reviews;

(b) For the review of applications for insurers or private review agents seeking registration renewal to continue as a utilization review entity;

(c) Ensuring that no registration shall be approved unless the commissioner has documentation or findings that all applicants seeking registration or renewal to conduct utilization review are in compliance with the requirements and procedures established regarding utilization review, and as to renewals, have complied with Sections 1 to 17 of this Act and administrative regulations promulgated to enforce and to administer Sections 1 to 17 of this Act; and

(d) Establishing fees for applications and renewals in an amount sufficient to pay the administrative costs of the program and any other costs associated with carrying out the provisions of Sections 1, 2, 3, 4, 5, 6, 7, and 8 of this Act.

(2) The registration issued in accordance with this section expires on the second anniversary of the effective date unless it is renewed.

(3) The registration issued under this section is not transferable.

(4) The commissioner may revoke or suspend the utilization review registration of any insurer or private review agent who does not comply with the requirements and procedures established regarding utilization review or any administrative regulations promulgated thereunder.

(5) The department shall establish reporting requirements to:

(a) Evaluate the effectiveness of insurers and private review agents; and

(b) Determine if the utilization review plans are in compliance with the requirements and procedures established regarding utilization review and applicable administrative regulations.

(6) Upon request of any provider, authorized person, or covered person whose care is subject to review, the department shall provide copies of policies or procedures of any insurer or private review agent that has been issued a registration by the department to conduct review in this state.

(7) Notwithstanding any provision to the contrary, an insurer or private review agent registered and in good standing under the provisions of KRS 211.461 to 211.466, prior to the effective date of this Act, shall be deemed in compliance with requirements and procedures established in Sections 1 to 17 of this Act regarding utilization review and registered accordingly.

(8) Upon receipt of written complaints from covered persons, authorized persons, or providers stating that an insurer or a private review agent has failed to perform a review in accordance with the utilization review plan or the requirements and procedures established regarding utilization review, or administrative regulations promulgated thereunder, the commissioner shall:

(a) Send a copy of the complaint to the insurer or the private review agent within ten (10) days of receipt of the complaint, and require that any written reply be sent to the commissioner within ten (10) days; and

(b) Review the complaint and any written reply received from the insurer or private review agent within the time frames set forth in paragraph (a) of this subsection and make a recommendation to the insurer or private review agent and the covered person, authorized person, or provider.

(9) The commissioner shall consider complaints before issuing or renewing any registration or renewal of a registration to an insurer or a private review agent.

SECTION 8. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) No insurer or any other person providing or administering a health benefit plan shall deny or reduce payment for a service, procedure, treatment, drug or device covered under the covered person's health benefit plan if:

(a) The covered person's provider, during normal business hours, contacts the insurer, the designee, or agent on the day the covered person is expected to be discharged, in order to request review of the covered person's continued hospitalization, and the insurer, designee, or agent fails to provide a timely utilization review decision as required by Section 4 of this Act; or

(b) The covered person's provider makes at least three (3) documented attempts during a four (4) consecutive hour period to contact the insurer, designee, or agent, during normal business hours in order to request review of a continued hospital stay, preauthorization of treatment for a covered person who is already hospitalized, or retrospective review of an emergency hospital admission where the covered person remains hospitalized at the time the review requested is made, and the insurer, designee, or private review agent fails to be accessible as required by Section 4 of this Act.

(2) The insurer's liability to pay for the covered person's hospitalization under the circumstances set forth in subsection (1) of this section shall extend until the insurer, designee, or private review agent issues a utilization review decision applicable to requests for review relating to matters as set forth in subsection 1(b) of this section.

(3) The insurer's liability to pay under this section shall be conditioned on :

(a) The provider establishing verifiable documentation of the contact with, and subsequent failure of the insurer, designee, or agent to make the utilization review decision as set forth in subsection (1)(a) of this section; or

(b) The provider establishing verifiable documentation of the attempt to make contact with the insurer, designee, or agent as addressed in subsection (1)(b) of this section.

(4) In either instance, the contact, or attempts to contact, as set forth in this section, shall be made by the means required by the insurer, designee, or agent for requesting utilization review.

(5) This section applies only when the request for review concerns covered health benefits and it shall not supersede any limitations or exclusions in the covered person's health benefit plan. This section shall not apply if, in requesting a review, the provider does not furnish the information requested by the insurer or agent to make a utilization review decision, or if actions by the provider impede an insurer's or private review agent's ability to issue a utilization review decision.

SECTION 9. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and Section 10 of this Act and which shall be disclosed to covered persons in accordance with subsection (1)(g) of Section 27 of this Act. An insurer shall disclose the availability of the internal review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in subsection (1)(i) of Section 4 of this Act. For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for review by the department.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall

be considered and providers given the opportunity to present additional information;

(e) To facilitate expeditious handling of an appeal of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the person undertaking an appeal with a denial letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The name, state of licensure, medical license number, and the title of the person making the decision;

3. A description of other alternative treatments, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating an internal appeal of the adverse determination, or filing a request for review with the department where a coverage denial is upheld by the insurer on internal appeal.

(3) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection "coverage denials" shall not include an adverse determination as defined in Section 1 of this Act or subsequent denials arising from an adverse determination.

(a) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within five (5) days receipt of notice to the insurer;

(b) Within five (5) days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person on the date of service under a health benefit plan issued by the insurer;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available;

(c) In addition to the information described in paragraph (b) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review;

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the

covered person's health benefit plan. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under Section 11, 12, and 13 of this Act, where the conditions precedent to the review are present. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

SECTION 10. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) If the covered person, authorized person, or provider has new clinical information regarding the covered person's internal appeal he or she shall provide that information to the insurer prior to the initiation of the external review process. The insurer shall have five (5) business days from the date of the receipt of the information to render a decision based on the new information. If new information is provided in accordance with this section, the sixty (60) day time frame for commencing an external review as set forth in subsection (4) of Section 12 of this Act, shall not begin to run, until the insurer or its designee renders a decision regarding the new information.

(2) The insurer's failure to make a determination or provide a written notice within the time frames set forth in Section 9 of this Act shall be deemed to be an adverse determination by the insurer for the purpose of initiating an external review as set forth in Section 12 of this Act.

SECTION 11. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The Independent External Review Program is hereby established in the department. The program shall provide covered persons with a formal, independent review to address disagreements between the covered person and the covered person's insurer regarding an adverse determination made by the insurer, its designee, or a private review agent. This section and Sections 12 and 13 establish requirements and procedures governing external review and independent review entities.

SECTION 12. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with subsection (1)(g) of Section 27 of this Act. An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in subsection (1)(i) of Section 4 and subsections (1) and (2)(e) of Section 9 of this Act. For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) The insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in subsection (2) of Section 10 of this Act. The insurer and the covered person may however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if not covered by the insurer.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in subsection (1) of Section 10 of this Act, of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department

shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and

2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in Section 9 of this Act.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the date of its receipt of notice of the adverse determination from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days of receipt of the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

SECTION 13. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:

(a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:

1. The covered person's medical records;

2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and

3. The insurer's health benefit plan.

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the Health Care Financing Administration of the United States Department of Health and Human Services, and the Agency for Health Care Research and Policy; and

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies.

(2) The independent review entity shall base its decision on the information submitted under subsection (1) of this section. In making its decision, the independent review entity shall consider safety, appropriateness, and cost effectiveness.

(3) The insurer shall provide any coverage determined by the independent review entity to be medically necessary. The independent review entity shall not be permitted to allow coverage for services specifically limited or excluded by the insurer in its health benefit plan. The decision shall apply only to the individual covered person's external review.

(4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in KRS 304.17A-515(1)(c) and 304.17A-550 .

(5) The insurer shall be responsible for the cost of the external review.

(6) The independent review entity shall provide to the covered person, treating provider, insurer, and the department a decision which shall include:

(a) The findings for either the insurer or covered person regarding each issue under review;

(b) The proposed service, treatment, drug, device, or supply for which the review was performed;

(c) The relevant provisions in the insurer's health benefit plan and how applied; and

(d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

(7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.

(8) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the adverse determination. The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature sufficient to warrant the commissioner revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in Section 18 of this Act.

(10) Failure to provide coverage as required by the independent review entity shall also subject the insurer to the provisions of KRS 304.99-010 and 304.99-020 and require the insurer to pay the claim that was the subject of the external review, without need for the covered person or authorized person to further establish a right as to the payment amount. Reasonable attorney fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.

(11) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in Sections 11, 12, and 13 of this Act.

(12) Nothing in Sections 1 to 17 of this Act shall be construed to create a cause of action against any of the following:

(a) An employer that provides health care benefits to employees through a health benefit plan;

(b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review addressed in Sections 1 to 17 of this Act; or

(c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in Sections 11, 12, and 13 of this Act.

(13) The covered person, insurer, or provider in the external review may submit written complaints to the department regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in Sections 11, 12, and 13 of this Act. The department shall promptly review the complaint, and if the department determines that the actions of the independent review entity were inappropriate, the department shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews. The department's actions shall be subject to the powers and administrative procedures set forth in subtitle 17A of KRS Chapter 304.

SECTION 14. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) To be certified as an independent review entity under this chapter, an organization shall submit to the department an application on a form required by the department. The application shall include the following:

(a) The name of each stockholder or owner of more than five percent (5%) of any stock or options for an applicant;

(b) The name of any holder of bonds or notes of the applicant that exceeds one hundred thousand dollars ($100,000);

(c) The name and type of business of each corporation or other organization that the applicant controls or with which it is affiliated and the nature and extent of the affiliation or control;

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under paragraph (c) of this subsection and a description of any relationship the named individual has with an insurer as defined in Section 1 of this Act or a provider of health care services;

(e) The percentage of the applicant's revenues that are anticipated to be derived from independent reviews;

(f) A description of the minimum qualifications employed by the independent review entity to select health care professionals to perform external review, their areas of expertise, and the medical credentials of the health care professionals currently available to perform external reviews; and

(g) The procedures to be used by the independent review entity in making review determinations; and

(2) If at any time there is a material change in the information included in the application, provided for in subsection (1) of this section, the independent review entity shall submit updated information to the department.

(3) The independent review entity shall annually submit to the department the information required by subsection (1) of this section in a form acceptable to the department.

(4) An independent review entity shall not be a subsidiary of, or in any way affiliated with, or owned, or controlled by an insurer or a trade or professional association of payors.

(5) An independent review entity shall not be a subsidiary of, or in any way affiliated with, or owned, or controlled by a trade or professional association of providers.

(6) Health care professionals who are acting as reviewers for the independent review entity shall hold in good standing a nonrestricted license in a state of the United States.

(7) Health care professionals who are acting as reviewers for the independent review entity shall hold a current certification by a recognized American medical specialty board or other recognized health care professional boards in the area appropriate to the subject of the review, be a specialist in the treatment of the covered person's medical condition under review, and have actual clinical experience in that medical condition.

(8) The independent review entity shall have a quality assurance mechanism to ensure the timeliness and quality of the review, the qualifications and independence of the physician reviewer, and the confidentiality of medical records and review material.

(9) Neither the independent review entity nor any reviewers of the entity, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(a) The insurer involved in the review;

(b) Any officer, director, or management employee of the insurer;

(c) The provider proposing the service or treatment or any associated independent practice association;

(d) The institution at which the service or treatment would be provided;

(e) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review; or (f) The covered person.

(10) As used in this section, "conflict of interest" shall not be interpreted to include:

(a) A contract under which an academic medical center or other similar medical center provides health care services to covered persons, except for academic medical centers that may provide the service under review;

(b) Provider affiliations which are limited to staff privileges; or

(c) A specialist reviewer's relationship with an insurer as a contracting health care provider, except for a specialist reviewer proposing to provide the service under review.

(11) On an annual basis, the independent review entity shall report to the department the following information:

(a) The number of independent review decisions in favor of covered persons ;

(b) The number of independent review decisions in favor of insurers;

(c) The average turnaround time for an independent review decision;

(d) The number of cases in which the independent review entity did not reach a decision in the time specified in statute or administrative regulation; and (e) The reasons for any delay.

SECTION 15. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The commissioner shall promulgate administrative regulations to implement the provisions of Sections 11,12 13, 14, 15, and 16 of this Act.

SECTION 16. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

Insurers subject to the administrative regulations required under Section 15 of this Act shall have no less than ninety (90) days to comply with the provisions of the administrative regulations.

SECTION 17. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The commissioner shall report every six (6) months to the Interim Joint Committee on Banking and Insurance, and to the Governor on the state of the Independent External Review Program. The report shall include a summary of the number of reviews conducted, medical specialties affected, and a summary of the findings and recommendations made by the independent external review entity.

Section 18. KRS 304.12-230 is amended to read as follows:

It is an unfair claims settlement practice for any person to commit or perform any of the following acts or omissions:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

(10) Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;~~[or]~~

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement***; or***

(15) ***Failing to comply with the decision of an independent review entity to provide coverage for a covered person as a result of an external review in accordance with Sections 11, 12, and 13 of this Act***.

SECTION 19. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

For purposes of Sections 19, 20, 21, 22, and 23 of this Act "Emergency medical condition" means:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a

condition that the absence of immediate medical attention could reasonably be expected to result in:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions:

(a) A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

(b) A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

SECTION 20. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Where a covered person with an emergency medical condition has been stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 42 U.S.C. sec. 300bb, in the emergency department of a nonparticipating hospital, and an insurer under its health benefit plan requires prior authorization for poststabilization treatment, approval or denial under the preauthorization requirement shall be provided in a timely manner appropriate to conditions of the patient and delivery of the services, but in no case to exceed two (2) hours from the time the request is made and all relevant information is provided. The insurer's failure to make a determination within the two (2) hour time frame, shall constitute an authorization for the hospital to provide the medical service for which prior authorization was sought.

(2) The nonparticipating hospital providing emergency room services, poststabilization treatment, or both, shall be paid at a rate negotiated between the nonparticipating hospital and the insurer. Nothing in this section is to be construed as requiring the payment of one hundred percent (100%) of the billed charges.

SECTION 21. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) "Special circumstances" includes a circumstance in which a covered person has a disability, a congenital condition, a life-threatening illness, or is past the twenty-fourth week of pregnancy where disruption of the covered person's continuity of care could cause medical harm.

(2) Any special circumstance shall be identified by the treating provider, who may request, with the concurrence of the covered person or authorized person, that the covered person be permitted to continue treatment under the provider's care even when the provider is no longer participating in the network, unless the provider has been terminated for a reason related to quality. The treating, non network provider shall agree to care for the covered person under the same guidelines and payment schedule as required by the plan, and shall report to the plan on the care being provided.

(3) Procedures for resolving disputes regarding the necessity for continued treatment by a provider shall be established by the plan and shall provide for review through the plan's internal appeal process.

(4) This section does not extend the obligation of the plan to pay a terminated or nonrenewed provider for ongoing treatment of a covered person with "special circumstances": (a) Beyond the ninetieth day after the effective date of the termination or nonrenewal;

(b) Beyond nine (9) months in the case of a covered person who at the time of the termination has been diagnosed with a terminal illness; or

(c) If the covered person is beyond the twenty-fourth week of pregnancy, the plan's obligation to pay for services extends through the delivery of the child, immediate postpartum care, and examination within the first six (6) weeks following delivery.

SECTION 22. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

An insurer shall not, under its health benefit plan prohibit a primary care physician from authorizing a covered person's referral to a participating nonprimary care physician specialist. A primary care physician treating a covered person who has a chronic, disabling, congenital, or life-threatening condition may authorize a referral to a participating nonprimary care physician specialist, up to twelve (12) months or for the contract period, whichever is shorter. Under this referral arrangement the covered person shall have direct access to the nonprimary care physician specialist, without the need of further contact or referral by the primary care physician.

SECTION 23. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer shall not, under its health benefit plan prohibit a primary care physician from authorizing a covered person's referral to a participating obstetrician or gynecologist. A primary care physician treating a covered person who is pregnant or has a chronic gynecological condition may authorize a referral to a participating obstetrician or gynecologist, up to twelve (12) months or for the contract period, whichever is shorter. Under this referral arrangement the covered person shall have direct access to the obstetrician or gynecologist, without the need of further contact or referral by the primary care physician.

(2) A female covered person shall be covered for an annual pap smear performed by an obstetrician or gynecologist without a referral from a primary care provider.

SECTION 24. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The commissioner shall promulgate administrative regulations necessary to implement the provisions of Sections 19, 20, 21, 22, and 23 of this Act.

Section 25. KRS 304.17A-520 is amended to read as follows:

(1) An enrollee shall have adequate choice among participating primary care providers in a managed care plan who are accessible and qualified.

(2) A managed care plan shall permit enrollees to choose their own primary care provider from a list of health care providers within the plan. This list shall be updated as health care providers

are added or removed and shall include a sufficient number of primary care providers who are accepting new enrollees.

(3) Women shall be able to choose a qualified health care provider offered by a plan for the provision of covered care necessary to provide routine and preventive women's health care services.

(4) A managed care plan shall provide an enrollee with access to a consultation with a participating health care provider for a second opinion. ***Obtaining the second opinion shall not cost a covered person more than the covered person's normal copay.***

Section 26. KRS 304.17-412 is amended to read as follows:

(1) Every health insurer proposing to issue or deliver in this state a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital benefits and the utilization review of those benefits by ***an insurer, its designee, or*** a private review agent shall:

(a) Be~~[a]~~ registered~~[private review agent]~~ in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~; or

(b) Contract with a private review agent that has been registered in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~.

(2) Notwithstanding any other provision of ***Sections 2, 3, 4, 5, 6, 7, and 8 of this Act***~~[KRS 211.461 to 211.466]~~, an insurer ***or its designee*** shall not deny or reduce payment of health benefits to any person, licensed practitioner, or health facility for covered services which have been rendered to an insured unless:

(a) Notice of denial has been issued. The notice shall inform patients***, authorized persons,*** and health-care providers of their right to appeal adverse determinations of ***a utilization review by*** the ***insurer, its designee, or*** private review agent to the ***insurer for the internal review process established by the insurer in accordance with Sections 9 and 10 of this Act***~~[Cabinet for Health Services under the dispute resolution process established pursuant to KRS 211.464(1)(g)]~~. The notice shall also include instructions on filing an ***internal*** appeal~~[to the cabinet]~~; and (b) The insurer is in compliance with subsection (1) of this section.

Section 27. KRS 304.17A-505 is amended to read as follows:

An insurer shall disclose in writing to ***a covered person and*** an enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health ***benefit plan***~~[insurance contract]~~ and shall promptly provide the ***covered person and*** enrollee with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(1) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to ***the following:***

1. ***A utilization review*** ~~[appeal]~~ and the procedure for initiating ***a utilization review, if an insurer elects to provide utilization review;***

2. An ***internal*** appeal of a utilization ***review*** ~~[management decision]~~ made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit or the denial of payment for a health care service***, and the procedure to initiate an internal appeal***; ***and***

3. ***An external review and the procedure to initiate the external review process.***

(h) ~~[The procedure to initiate an appeal through the process under KRS 211.464(1)(g);~~

~~(i)]~~ Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider; and

(i) ~~[(j)]~~ Other information as the commissioner shall require by administrative regulation.

(2) The insurer shall file the information required under this section with the department.

Section 28. KRS 304.18-045 is amended to read as follows:

(1) Every health insurer proposing to issue or deliver in this state a group or blanket health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital benefits and the utilization review of those benefits by ***an insurer, its designee, or*** a private review agent shall:

(a) Be ~~[a]~~ registered ~~[private review agent]~~ in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act*** ~~[KRS 211.462]~~; or

(b) Contract with a private review agent that has been registered in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act*** ~~[KRS 211.462]~~.

(2) Notwithstanding any other provision of ***Sections 2, 3, 4, 5, 6, 7, and 8 of this Act*** ~~[KRS 211.461 to 211.466]~~, an insurer ***or its designee*** shall not deny or reduce payment of health benefits to any person, licensed practitioner, or health facility for covered services which have been rendered to an insured unless:

(a) Notice of denial has been issued. The notice shall inform patients***, authorized persons,*** and health-care providers of their right to appeal adverse determinations of ***a utilization review by*** the ***insurer, its designee, or*** private review agent to the ***insurer for the internal review process established by the insurer in accordance with Sections 9 and 10 of this Act*** ~~[Cabinet for Health Services under the dispute resolution process established pursuant to KRS 211.464(1)(g)]~~. The notice shall also include instructions on filing an ***internal*** appeal ~~[to the cabinet]~~; and

(b) The insurer is in compliance with subsection (1) of this section.

Section 29. KRS 304.32-147 is amended to read as follows:

(1) Every nonprofit hospital, medical-surgical, dental, and health service corporation proposing to issue or deliver in this state a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital benefits and the utilization review of those benefits by a private review agent shall:

(a) Be a registered private review agent in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~; or

(b) Contract with a private review agent that has been registered in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~.

(2) Notwithstanding any other provision of ***Sections 2, 3, 4, 5, 6, 7, and 8 of this Act***~~[KRS 211.461 to 211.466]~~, a nonprofit hospital, medical-surgical, dental, and health service corporation shall not deny or reduce payment of health benefits to any person, licensed practitioner, or health facility for covered services which have been rendered to an insured unless:

(a) Notice of denial has been issued. The notice shall inform patients***, authorized persons,*** and health-care providers of their right to appeal adverse determinations of ***a utilization review by*** the ***insurer, its designee, or*** private review agent to the ***insurer for the internal appeal process established by the insurer in accordance with Sections 9 and 10 of this Act***~~[Cabinet for Health Services under the dispute resolution process established pursuant to KRS 211.464(1)(g)]~~. The notice shall also include instructions on filing an appeal to the cabinet; and

(b) The nonprofit hospital, medical-surgical, dental, and health service corporation is in compliance with subsection (1) of this section.

Section 30. KRS 304.32-330 is amended to read as follows:

(1) Every employer in this state which provides coverage of hospital benefits on a self-insured basis and requires the utilization review of such benefits by ***an insurer, its designee, or*** a private review agent shall:

(a) Be a registered private review agent in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~; or

(b) Contract with a private review agent that has been registered in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~.

(2) Notwithstanding any other provision of ***Sections 2, 3, 4, 5, 6, 7, and 8 of this Act***~~[KRS 211.461 to 211.466]~~, a self-insured employer shall not deny or reduce payment of health benefits to any person, licensed practitioner, or health facility for covered services which have been rendered to an insured unless:

(a) Notice of denial has been issued; and

(b) The self-insured employer is in compliance with subsection (1) of this section.

Section 31. KRS 304.38-225 is amended to read as follows:

(1) Every health maintenance organization in this state which provides coverage of hospital benefits and requires the utilization review of such benefits or administers a health benefit program which provides for the coverage of hospital benefits and requires the utilization review of such benefits by a private review agent shall:

(a) Be a registered private review agent in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~; or

(b) Contract with a private review agent that has been registered in accordance with ***Section 4 of this Act and administrative regulations promulgated under the authority of Section 7 of this Act***~~[KRS 211.462]~~.

(2) Notwithstanding any other provision of ***Sections 2, 3, 4, 5, 6, 7, and 8 of this Act***~~[KRS 211.461 to 211.466]~~, a health maintenance organization shall not deny or reduce payment of health benefits to any person, licensed practitioner, or health facility for covered services which have been rendered to an insured unless:

(a) Notice of denial has been issued. The notice shall inform patients***, authorized persons,*** and health-care providers of their right to appeal adverse determinations of ***a utilization review by*** the ***insurer, its designee, or*** private review agent to the ***insurer for the internal review process established by the insurer in accordance with Sections 9 and 10 of this Act***~~[Cabinet for Health Services under the dispute resolution process established pursuant to KRS 211.464(1)(g)]~~. The notice shall also include instructions on filing an ***internal*** appeal~~[to the cabinet]~~; and

(b) The health maintenance organization is in compliance with subsection (1) of this section.

Section 32. KRS 304.47-050 is amended to read as follows:

(1) Any person, other than an insurer, agent, or other person licensed under this chapter, or an employee thereof, having knowledge or believing that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under the subtitle is being or has been committed may send to the Division of Insurance Fraud Investigation a report of information pertinent to this knowledge of or belief and any additional relevant information the commissioner may request.

(2) The following individuals having knowledge or believing that a fraudulent insurance act or any other act or practice which may constitute a felony or misdemeanor under this subtitle is being or has been committed shall send to the Division of Insurance Fraud Investigation a report or information pertinent to the knowledge or belief and additional relevant information that the commissioner or his employees or agents may require:

(a) Any professional practitioner licensed or regulated by the Commonwealth, except as provided by law;

(b)~~[Any utilization review of benefits committee as defined in KRS 211.462 to 211.466;~~

~~(c)]~~ Any private medical review committee;

(c) ~~[(d)]~~ Any insurer, agent, or other person licensed under this chapter; and

(d) ~~[(e)]~~ Any employee of the persons named in paragraphs (a) to ***(c)*** ~~[(d)]~~ of this subsection.

(3) The Division of Insurance Fraud Investigation or its employees or agents shall review this information or these reports and select the information or reports that, in the judgment of the division, may require further investigation. The division shall then cause an investigation of the facts surrounding the information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under this subtitle is being committed.

(4) The Department of Workers' Claims shall provide the division access to all relevant information the commissioner may request.

(5) The Division of Insurance Fraud Investigation shall report any alleged violations of law which the investigations disclose to the appropriate licensing agency and the Commonwealth's attorney, Attorney General, or other prosecuting agency having jurisdiction with respect to a violation. If prosecution by the Commonwealth's attorney, Attorney General, or other prosecuting agency is not begun within sixty (60) days of the report, the prosecuting attorney shall inform the division of the reasons for the lack of prosecution. In addition to filing a report with the appropriate prosecuting agency, the commissioner may, through the Attorney General, prosecute violations of this subtitle in the Circuit Court of the county in which the alleged wrongdoer resides or has his principal place of business, in the Circuit Court of the county in which the fraudulent insurance act has been committed, or, with consent of the parties, in the Franklin Circuit Court.

(6) Notwithstanding the provisions of subsections (1) to (5) of this section, when an insurer or an insured knows or has reasonable grounds to believe that a person committed a fraudulent insurance act which the insurer reasonably believes not to have been reported to a law enforcement agency in this state, then, for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf or the insured may notify a law enforcement agency of their knowledge or reasonable belief and provide information relevant to the fraudulent insurance act, including, but not limited to, insurance policy information including the application for insurance, policy premium payment records, history of previous claims made by the insured, and other information relating to the investigation of the claim, including statements of any person, proofs of loss, and notice of loss.

(7) If the information referred to in subsection (6) of this section is specifically requested by a law enforcement agency or prosecuting attorney, the insurer shall provide certified copies of the requested information within ten (10) business days of the request or as soon thereafter as reasonable.

(8) In the absence of malice, fraud, or gross negligence, no insurer or agent authorized by an insurer to act on its behalf, law enforcement agency, the Department of Workers' Claims, their respective employees, or an insured shall be subject to any civil liability for libel, slander, or related cause of action by virtue of filing reports or for releasing or receiving any information pursuant to this subsection.

Section 33. KRS 211.990 is amended to read as follows:

(1) Any owner or occupant who fails to comply with an order made under the provisions of KRS 211.210 shall be guilty of a violation, and each day's continuance of the nuisance, source of

filth, or cause of sickness, after the owner or occupant has been notified to remove it, shall be a separate offense.

(2) Except as otherwise provided by law, anyone who fails to comply with the provisions of the rules and regulations adopted pursuant to this chapter or who fails to comply with an order of the cabinet issued pursuant thereto shall be guilty of a violation. Each day of such violation or noncompliance shall constitute a separate offense.

(3) Any person who violates any provision of KRS 211.182 shall, upon first offense, be guilty of a Class A misdemeanor. Each subsequent violation of any provision of KRS 211.182 shall constitute a Class D felony.

(4) Any person who violates any provision of KRS 211.842 to 211.852 or any regulation adopted hereunder or any order issued by the Cabinet for Health Services to comply with any provision of KRS 211.842 to 211.852 or the regulations adopted thereunder shall be guilty of a Class A misdemeanor. Each day of violation or noncompliance shall constitute a separate offense.

(5) Any person who violates KRS 211.962 or any rule or regulation of the Cabinet for Health Services adopted pursuant to KRS 211.962 to 211.968 shall be guilty of a Class A misdemeanor.

(6)~~[A private review agent which performs utilization review without proper registration pursuant to KRS 211.461 to 211.466 shall be guilty of a Class A misdemeanor.~~

~~(7) Any properly registered private review agent which willfully violates any provision of KRS 211.461 to 211.466 or of the regulations shall be guilty of a Class D felony.~~

~~(8)]~~ A person who performs or offers to perform lead-hazard detection or lead-hazard abatement services in target housing or child-occupied facilities who is not certified as required by KRS 211.9063 or 211.9069 shall be guilty of a Class A misdemeanor.

(7)~~[(9)]~~ Any person who performs lead-hazard detection or lead-hazard abatement services in target housing or child-occupied facilities, who willfully violates the standards for performing lead-hazard detection or lead-hazard abatement procedures included in the administrative regulations promulgated pursuant to KRS 211.9075 shall be guilty of a Class D felony.

(8)~~[(10)]~~ The penalties provided in subsections (6), ***and*** (7)~~[, (8), and (9)]~~ of this section are cumulative and are in addition to any other penalties, claims, damages, or remedies available at law or in equity.

(9)~~[(11)]~~ Any person who violates any provisions of KRS 211.760 shall be fined not less than ten dollars ($10) nor more than one hundred dollars ($100). Each day of violation or noncompliance shall constitute a separate offense.

Section 34. KRS 311.990 is amended to read as follows:

(1) Any person who violates KRS 311.250 shall be guilty of a violation.

(2) Any college or professor thereof violating the provisions of KRS 311.300 to 311.350 shall be civilly liable on his bond for a sum not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each violation, which may be recovered by an action in the name of the Commonwealth.

(3) Any person who presents to the county clerk for the purpose of registration any license which has been fraudulently obtained, or obtains any license under KRS 311.380 to 311.510 by false

or fraudulent statement or representation, or practices podiatry under a false or assumed name or falsely impersonates another practitioner or former practitioner of a like or different name, or aids and abets any person in the practice of podiatry within the state without conforming to the requirements of KRS 311.380 to 311.510, or otherwise violates or neglects to comply with any of the provisions of KRS 311.380 to 311.510, shall be guilty of a Class A misdemeanor. Each case of practicing podiatry in violation of the provisions of KRS 311.380 to 311.510 shall be considered a separate offense.

(4) Each first violation of KRS 311.560 is a Class A misdemeanor. Each subsequent violation of KRS 311.560 shall constitute a Class D felony.

(5) Each violation of KRS 311.590 shall constitute a Class D felony. Conviction under this subsection of a holder of a license or permit shall result automatically in permanent revocation of such license or permit.

(6) Conviction of willfully resisting, preventing, impeding, obstructing, threatening, or interfering with the board or any of its members, or of any officer, agent, inspector, or investigator of the board or the Cabinet for Health Services, in the administration of any of the provisions of KRS 311.550 to 311.620 shall be a Class A misdemeanor.

(7) Each violation of subsection (1) of KRS 311.375 shall, for the first offense, be a Class B misdemeanor, and, for each subsequent offense shall be a Class A misdemeanor.

(8) Each violation of subsection (2) of KRS 311.375 shall, for the first offense, be a violation, and, for each subsequent offense, be a Class B misdemeanor.

(9) Each day of violation of either subsection of KRS 311.375 shall constitute a separate offense.

(10) (a) Any person who intentionally or knowingly performs an abortion contrary to the requirements of KRS 311.723(1) shall be guilty of a Class D felony; and

(b) Any person who intentionally, knowingly, or recklessly violates the requirements of KRS 311.723(2) shall be guilty of a Class A misdemeanor.

(11) (a) 1. Any physician who performs a partial-birth abortion in violation of KRS 311.765 shall be guilty of a Class D felony. However, a physician shall not be guilty of the criminal offense if the partial-birth abortion was necessary to save the life of the mother whose life was endangered by a physical disorder, illness, or injury.

2. A physician may seek a hearing before the State Board of Medical Licensure on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, illness, or injury. The board's findings, decided by majority vote of a quorum, shall be admissible at the trial of the physician. The board shall promulgate administrative regulations to carry out the provisions of this subparagraph.

3. Upon a motion of the physician, the court shall delay the beginning of the trial for not more than thirty (30) days to permit the hearing, referred to in subparagraph 2. of this paragraph, to occur.

(b) Any person other than a physician who performs a partial-birth abortion shall not be prosecuted under this subsection but shall be prosecuted under provisions of law which prohibit any person other than a physician from performing any abortion.

(c) No penalty shall be assessed against the woman upon whom the partial-birth abortion is performed or attempted to be performed.

(12) Any person who intentionally performs an abortion with knowledge that, or with reckless disregard as to whether, the person upon whom the abortion is to be performed is an unemancipated minor, and who intentionally or knowingly fails to conform to any requirement of KRS 311.732 is guilty of a Class A misdemeanor.

(13) Any person who negligently releases information or documents which are confidential under KRS 311.732 is guilty of a Class B misdemeanor.

(14) Any person who performs an abortion upon a married woman either with knowledge or in reckless disregard of whether KRS 311.735 applies to her and who intentionally, knowingly, or recklessly fails to conform to the requirements of KRS 311.735 shall be guilty of a Class D felony.

(15) Any person convicted of violating KRS 311.750 shall be guilty of a Class B felony.

(16) Any person who violates KRS 311.760(2) shall be guilty of a Class D felony.

(17) Any person who violates KRS 311.770 or 311.780 shall be guilty of a Class D felony.

(18) A person convicted of violating KRS 311.780 shall be guilty of a Class C felony.

(19) Any person who violates KRS 311.810 shall be guilty of a Class A misdemeanor.

(20) Any professional medical association or society, licensed physician, or hospital or hospital medical staff who shall have violated the provisions of KRS 311.606 shall be guilty of a Class B misdemeanor.

(21) Any person who violates KRS 311.652 or any rule or regulation of the board of medical licensure adopted pursuant to KRS 311.654 shall be guilty of a Class A misdemeanor.

(22) Any administrator, officer, or employee of a publicly-owned hospital or publicly-owned health care facility who performs or permits the performance of abortions in violation of KRS 311.800(1) shall be guilty of a Class A misdemeanor.

(23) Any person who violates KRS 311.914 shall be guilty of a violation.

(24) Any person who violates the provisions of KRS 311.820 shall be guilty of a Class A misdemeanor.

(25) (a) Any person who fails to test organs, skin, or other human tissue which is to be transplanted, or violates the confidentiality provisions required by KRS 311.281, shall be guilty of a Class A misdemeanor;

(b) Any person who has human immunodeficiency virus infection, who knows he is infected with human immunodeficiency virus, and who has been informed that he may communicate the infection by donating organs, skin, or other human tissue who donates organs, skin, or other human tissue shall be guilty of a Class D felony.

(26)~~[A person who violates any provision of KRS 311.131 to 311.139 or any regulation adopted under KRS 311.131 to 311.139 shall be guilty of a Class A misdemeanor. Each day a violation is continued after the first conviction shall be a separate offense.~~

~~(27)]~~ Any person who sells or makes a charge for any transplantable organ shall be guilty of a Class D felony.

(27) ~~[(28)]~~ Any person who offers remuneration for any transplantable organ for use in transplantation into himself shall be fined not less than five thousand dollars ($5,000) nor more than fifty thousand dollars ($50,000).

(28) ~~[(29)]~~ Any person brokering the sale or transfer of any transplantable organ shall be guilty of a Class C felony.

(29) ~~[(30)]~~ Any person charging a fee associated with the transplantation of a transplantable organ in excess of the direct and indirect costs of procuring, distributing, or transplanting the transplantable organ shall be fined not less than fifty thousand dollars ($50,000) nor more than five hundred thousand dollars ($500,000).

(30) ~~[(31)]~~ Any hospital performing transplantable organ transplants which knowingly fails to report the possible sale, purchase, or brokering of a transplantable organ shall be fined not less than ten thousand dollars ($10,000) or more than fifty thousand dollars ($50,000).

Section 35. The following KRS section is repealed:

211.461 Definitions.

211.462 Registration of private review agent required -- Exceptions.

211.463 Duties of private review agent regarding utilization review.

211.464 Regulations -- Reporting requirements -- Copies of policies or procedures -- List of registered agents.

211.465 Procedures for registration and renewal.

211.466 Enjoining operation of improperly registered agent.

311.131 Definitions.

311.132 Certificate required for private review agent -- Exceptions.

311.133 Administrative regulations.

311.134 Requirements for health benefit program covering hospital and medical benefits and utilization review thereof.

311.135 Application for a certificate.

311.136 Expiration and renewal of certificate.

311.137 Revocation or denial of certificate.

311.138 Hearing and appeal.

311.139 Confidentiality of individual medical records.

Approved March 31, 2000