CHAPTER 500

(HB 757)

AN ACT relating to health insurance.

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

SECTION 1. A NEW SECTION OF KRS 304.17A-500 TO 304.17A-590 IS CREATED TO READ AS FOLLOWS:

(1) A managed care plan as defined in Section 5 of this Act shall file with the commissioner sample copies of any agreements it enters into with providers for the provision of health care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

(a) A hold harmless clause that states that the provider may not, under any circumstance, including:

1. Nonpayment of moneys due the providers by the managed care plan,

2. Insolvency of the managed care plan, or 3. Breach of the agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

(b) A continuity of care clause that states that if an agreement between the provider and the managed care plan is terminated for any reason, other than a quality of care issue or fraud, the provider shall continue to provide services and reimburse the provider in accordance with the agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy;

(c) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the managed care plan; and

(d) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) An insurer that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement: (a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including, but not limited to, the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The commissioner shall have access to a specific risk sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the department shall be considered to be a trade secret and shall not be subject to KRS 61.872 to 61.884.

Section 2. KRS 304.17A-505 is amended to read as follows:

An insurer shall disclose in writing to an ***insured or*** enrollee, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health insurance contract and shall promptly provide the 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 appeal and the procedure for initiating an appeal of a utilization 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;

(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]~~

(j) Other information as the commissioner shall require by administrative regulation***;***

(k) ***A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured or enrollee, a complete drug formulary; and***

(l) ***A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer***.

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

Section 3. KRS 304.17A-510 is amended to read as follows:

(1) In addition to the disclosure requirements provided in KRS 304.17A-505, an insurer that offers a managed care plan shall disclose to an enrollee, in writing, in a manner consistent with KRS 304.14-420 to 304.14-450, the following information at the time of enrollment and upon request:

(a) A current participating provider directory providing information on a covered person's access to primary care health care providers, including available participating health care providers, by provider category or specialty and by county. The directory shall include the professional office address of each participating health care provider. The directory shall also provide information about participating hospitals and other providers. The insurer shall promptly notify each covered person on the termination or withdrawal from the insurer's provider network of the covered person's designated primary care provider;

(b) General information about the type of financial incentives between participating providers under contract with the insurer and other participating health care providers and facilities to which the participating providers refer their managed care patients;~~[and]~~

(c) The insurer's managed care plan's standard for customary waiting times for appointments for urgent and routine care***; and***

(d) ***The existence of any hold harmless agreements it has with providers and their effect on the enrollee***.

The insurer shall provide a prospective enrollee with information about the provider network, including hospital affiliations, and other information specified in this subsection, upon request.

(2) Upon request of a covered person, an insurer shall promptly inform the person:

(a) Whether a particular network provider is board certified; and

(b) Whether a particular network provider is currently accepting new patients.

(3) Each insurer shall annually make available to its enrollees at its principal office and place of business:

(a) Its most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements; and

(b) A current description of its organizational structure and operation.

Section 4. KRS 304.17A-515 is amended to read as follows:

(1) A managed care plan shall arrange for a sufficient number and type of primary care providers and specialists throughout the plan's service area to meet the needs of enrollees. Each managed care plan shall demonstrate that it offers:

(a) An adequate number of accessible acute care hospital services, where available;

(b) An adequate number of accessible primary care providers, including family practice and general practice physicians, internists, obstetricians/gynecologists, and pediatricians, where available;

(c) An adequate number of accessible specialists and subspecialists, and when the specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to nonparticipating health care providers with prior plan approval;

(d) The availability of specialty services; and

(e) ***A provider network that meets the following accessibility requirements:***

1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence or work, to the extent that services are available; or

2. For areas other than urban areas, a provider network that makes available primary care physician services, hospital services, and pharmacy services within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available

~~[A provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each person's place of residence, to the extent those services are available]~~.

(2) A managed care plan shall provide telephone access to the plan during business hours to ensure plan approval of nonemergency care. A managed care plan shall provide adequate information to enrollees regarding access to urgent and emergency care.

(3) A managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care. Section 5. KRS 304.17A-500 is amended to read as follows:

As used in KRS 304.17A-500 to ***304.17A-590***~~[304.17A-570]~~, unless the context requires otherwise:

(1) ***"Areas other than urban areas" means a classification code that does not meet the definition of urban area;***

(2) "Contract holder" means an employer or organization that purchases a contract for services;

(3)~~[(2)]~~ "Covered person" means a person on whose behalf an insurer offering the plan is obligated to pay benefits or provide services under the health insurance policy;

(4)~~[(3)]~~ "Emergency medical condition" means:

(a) 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:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part; or

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

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;

(5) ~~[(4)]~~ "Enrollee" means a person who is enrolled in a managed health care plan;

(6) ~~[(5)]~~ "Grievance" means a written complaint submitted by or on behalf of an enrollee;

(7) ~~[(6)]~~ "Health insurance policy" means "health benefit plan" as defined in KRS 304.17A005;

(8) ~~[(7)]~~ "Insurer" has the meaning provided in KRS 304.17A-005;

(9) ~~[(8)]~~ "Managed care plan" means a health insurance policy that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan;

(10) ~~[(9)]~~ "Participating health care provider" means a health care provider that has entered into an agreement with an insurer to provide health care services to an enrollee in its managed care plan;

(11) ~~[(10)]~~ "Quality assurance or improvement" means the ongoing evaluation by a managed care plan of the quality of health care services provided to its enrollees;

(12) ~~[(11)]~~ "Record" means any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient;~~[and]~~

(13) "Risk sharing arrangement" means any agreement that allows an insurer to share the financial risk of providing health care services to enrollees or insureds with another entity or provider where there is a chance of financial loss to the entity or provider as a result of the delivery of a service. A risk sharing arrangement shall not include a reinsurance contract with an accredited or admitted reinsurer.

(14) ~~[(12)]~~ ***"Urban area" means a classification code whereby the zip code population density is greater than three thousand (3,000) persons per square mile; and***

(15) "Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed,

covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

Section 6. KRS 304.17A-540 is amended to read as follows:

(1) Any insurer that limits coverage for any treatment, procedure, ***a*** drug, or device shall define the limitations and fully disclose those limits in the health insurance policy or certificate coverage.

(2) (a) Any insurer that denies coverage for a treatment, procedure, ***a*** drug ***that requires prior approval,*** or device for an enrollee shall provide the enrollee with a denial letter that shall include:

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

2. A statement setting forth the specific medical and scientific reasons for denying coverage ***of a service, if the coverage is denied for reasons of medical necessity***~~[or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;~~

3. ~~A description of other alternative treatment, services, or supplies covered by theplan, if any]~~; and

3.~~[4.]~~ Instructions for initiating or complying with the plan's grievance or appeal procedure stating at a minimum whether the appeal must be in writing, any time limitations or schedules for filing appeals and the name and phone number of a contact person who can provide additional information.

(b) The denial letter shall be provided within:

1. Two (2) regular working days of the submitted request where preauthorization for a treatment, procedure, drug, or device is involved;

2. Twenty-four (24) hours of the submitted request where hospital preadmission review is sought;

3. Twenty (20) working days of the receipt of requested medical information where the plan has initiated a retrospective review; and

4. Twenty (20) working days of the initiation of the review process in all other instances.

Section 7. KRS 304.17A-580 is amended to read as follows:

(1) ***An insurer offering*** health benefit plans shall educate their insureds about the availability, location, and appropriate use of emergency and other medical services, cost-sharing provisions for emergency services, and the availability of care outside an emergency department.

(2) ***An insurer offering*** health benefit plans~~[using a defined network of health care providers]~~ shall cover emergency ***medical conditions and shall pay for emergency*** department screening and stabilization services both in-network and out-of-network without prior authorization for ***conditions that reasonably appear to a prudent layperson to constitute an emergency***

medical condition based on the patient's presenting symptoms and condition. An insurer shall be prohibited from denying the emergency room services and altering the level of coverage or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition as defined in Section 5 of this Act~~[use consistent with the prudent layperson standard]~~.

(3) Emergency department personnel shall contact a patient's primary care provider or ***insurer***~~[health benefit plan]~~, as appropriate, as quickly as possible to discuss follow-up and poststabilization care and promote continuity of care. Section 8. KRS 304.17A-590 is amended to read as follows:

(1) An insurer that offers a managed care plan shall disclose to an enrollee, in writing, in a manner consistent with KRS 304.14-420 to 304.14-450, and any risk-bearing managed care plan shall disclose to an enrollee, in writing, at the time of enrollment and thereafter upon request, and as new providers are contracted with by the plans, or as the directory may change, a current participating provider directory providing information on a covered person's access to primary care physicians and specialists, optometrists, chiropractors, and hospitals, including available participating physicians, optometrists, chiropractors, and hospitals, by provider category or specialty and by county. The directory shall include the following:

(a) Professional office addresses and telephone numbers for all participating ***providers***~~[:~~

~~1. Primary care physicians;~~

~~2. Optometrists;~~

~~3. Chiropractors;~~

~~4. Hospitals; and~~

~~5. Other health care providers as defined under KRS 304.17A-010(11);~~

(b) ~~Information about drug formularies and their restrictions, limitations, and proceduresfor authorization outside the formularies]~~;

(b)~~[(c)]~~ The benefits for each provider type;

(c)~~[(d)]~~ General information about the type of financial incentives between participating providers under contract with the insurer and other participating health care providers and facilities to which the participating providers refer their managed care patients; and

(d)~~[(e)]~~ Grievance procedures available under the plans for complaint resolutions.

(2) The insurer shall promptly notify each covered person on the termination or withdrawal from the insurer's provider network of the covered person's designated primary care provider.

(3) The provisions of this section shall be implemented prior to any open enrollment period for which the effective date of coverage will be January 1, 1999, or for which the effective date

shall commence after an open enrollment period, and shall continue for each open enrollment period thereafter.

Section 9. KRS 304.17A-535 is amended to read as follows:

(1) A managed care plan shall include a drug utilization review program, the primary emphasis of which shall be to enhance quality of care for enrollees by assuring appropriate drug therapy

within the health care provider's legally authorized scope of practice, that includes the following:

(a) Retrospective review of prescription drugs furnished to enrollees;

(b) Education of health care providers and enrollees regarding the appropriate use of prescription drugs; and

(c) Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees.

(2) The drug utilization review program shall utilize the following to effectuate the purposes of subsection (1) of this section:

(a) Relevant clinical criteria and standards for drug therapy;

(b) Nonproprietary criteria and standards developed and revised through input from participating health care providers;

(c) Intervention that focuses on improving therapeutic outcomes; and

(d) Measures to ensure the confidentiality of the relationship between an enrollee and a health care provider.

(3) When, in the professional opinion of a provider with prescriptive authority, the provider determines that generic substitution of a pharmaceutical product is medically inappropriate, the provider shall prescribe the pharmaceutical product the provider determines medically appropriate with the indication "Do Not Substitute," and no substitution shall be made without the provider's approval.

(4) ***A managed care plan that restricts pharmacy benefits to a drug formulary shall have an exceptions policy through which the managed care plan may cover a prescription drug not included on the formulary.***

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

(1) Any insurer delivering or issuing a health benefit plan subject to this subtitle or a health insurance policy or contract covering specified disease shall give the policyholder or contract holder at least forty-five (45) days advance written notice of cancellation. The notice shall be mailed by registered mail to the policyholder's or contract holder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, at least fourteen (14) days written notice accompanied by the reason therefor shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies in the individual market under which premiums are payable monthly or more frequently and regularly collected by a licensed agent.

(2) On and after January 1, 2001, every insurer offering group health insurance coverage in the Commonwealth shall include in its contract with group policyholders or contract holders, regardless of the situs of the contract, a provision requiring the group policyholder or contract holder to mail promptly to each person covered under the group policy or contract a legible, true copy of any notice of cancellation of the group coverage which may be received from the insurer and to provide promptly to the insurer proof of that mailing and the date thereof. The notice of cancellation mailed by the group policyholder or contract holder to each person covered under the group policy or contract shall include

information regarding the conversion rights of covered persons upon termination of the group policy or contract. This information shall be in clear and easily understandable language.

(3) In the event of cancellation, the insurer shall return promptly the unearned portion of any premium paid. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(4) If the insurer fails to provide the forty-five (45) days notice required by this section, the coverage shall remain in effect at the existing premium until forty-five (45) days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.

Approved April 21, 2000