CHAPTER 521

(HB 608)

AN ACT relating to the public good.

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

Section 1. KRS 304.17A-005 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) ***"At the time of enrollment" means:***

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance.

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) ~~[(3)]~~ "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(5) ~~[(4)]~~ "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(6) ~~[(5)]~~ "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(7) ~~[(6)]~~ (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code;

9. A public health plan, as defined in regulations; or

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)).

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (10) of this section;

(8) ~~[(7)]~~ "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(9) ~~[(8)]~~ "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, no employerorganized association shall be treated as an association, small group, or large group under this subtitle;

(10) ~~[(9)]~~ "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(11) ~~[(10)]~~ "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan;

(12) ~~[(11)]~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(13) ~~[(12)]~~ "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals;

(14) ~~[(13)]~~ "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program;

(15) ~~[(14)]~~ "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(16) ~~[(15)]~~ "Guaranteed acceptance program qualified individual" means an individual who:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage ***or who is a spouse or a dependent of an individual who:***

1. Waived coverage under subsection (2) of Section 9 of this Act; or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(17) ~~[(16)]~~ "Guaranteed acceptance plan supporting insurer" means either an insurer that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored selfinsured health benefit plan exempted by ERISA;

(18) ~~[(17)]~~ "Health benefit plan" means 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; a self-insured plan or a plan 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, short-term coverage, 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;

(19) ~~[(18)]~~ "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Nurse practitioners licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(20) ~~[(19)]~~ (a) "High-cost condition" means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(21) ~~[(20)]~~ "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(22) ~~[(21)]~~ "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan;

(23) ~~[(22)]~~ "Insurer" means any insurance company; health maintenance organization; 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, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

(24) ~~[(23)]~~ "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(25) ~~[(24)]~~ "Large group" means:

(a) An employer with fifty-one (51) or more employees; or

(b) An affiliated group with fifty-one (51) or more eligible members;

(26) ~~[(25)]~~ "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate 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 for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(27) ~~[(26)]~~ "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(28) ~~[(27)]~~ "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(29) ~~[(28)]~~ "Provider-sponsored integrated health delivery network" means any providersponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(30) ~~[(29)]~~ "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(31) ~~[(30)]~~ "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(32) ~~[(31)]~~ "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(33) ~~[(32)]~~ "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(34)~~[(33)]~~ "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(35)~~[(34)]~~ "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members; and

(36)~~[(35)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250.

Section 2. KRS 304.17A-300 is amended to read as follows:

(1) A provider-sponsored integrated health delivery network may be created by health care providers for the purpose of providing health care services.

(2) No person shall in this Commonwealth be, act as, or hold itself out as a provider-sponsored integrated health delivery network unless it holds a certificate of filing from the commissioner. Each provider-sponsored integrated health delivery network that seeks to offer services shall first be certified by the department.

(3)~~[Notwithstanding subsection (2) of this section, a provider-sponsored integrated health delivery network which holds a certificate of filing from the Kentucky Health Policy Board as of July 15, 1996, shall have one (1) year from July 15, 1996, to comply with the provisions of this subtitle.~~

~~(4)]~~ To qualify as a provider-sponsored integrated health delivery network, an applicant shall submit information acceptable to the department to satisfactorily demonstrate that the provider-sponsored integrated health delivery network:

(a) Is licensed and in good standing with the licensure boards for participating providers;

(b) Has demonstrated the capacity to administer the health plans it is offering;

(c) Has the ability, experience, and structure to arrange for the appropriate level and type of health care services;

(d) Has the ability, policies, and procedures to conduct utilization management activities;

(e) Has the ability to achieve, monitor, and evaluate the quality and cost effectiveness of care provided by its provider network;

(f) Is financially solvent;

(g) Has the ability to assure enrollees adequate access to providers, including geographic availability and adequate numbers and types;

(h) Has the ability and procedures to monitor access to its provider network;

(i) Has a satisfactory grievance procedure and the ability to respond to enrollees' inquiries and complaints;

(j) Does not limit the participation of any health care provider in its provider network in another provider network;

(k) Has the ability and policies that allow patients to receive care in the most appropriate, least restrictive setting;

(l) Does not discriminate in enrolling members;

(m) Participates in coordination of benefits;

(n) Uses standardized electronic claims and billing processes and formats; ***and***

(o) Discloses to the cooperative reimbursement arrangements with providers~~[; and~~

(p) ~~Assures that all services covered by the provider-sponsored integrated health deliverynetwork are available to all persons enrolled in the plan within fifty (50) miles of each person's place of residence, to the extent those services are available within that area, and assures that all services not available therein shall be offered at sites as proximate to the enrollee as possible]~~.

(4)~~[(5)]~~ Fees for the following services shall be paid to the commissioner by every providersponsored integrated health delivery network, and the fees shall be the same as those for insurers as specified in Subtitle 4 of this chapter:

(a) For filing an application for a certificate of filing or amendment thereto;

(b) For filing an annual statement; and

(c) For other services deemed necessary by the commissioner.

(5)~~[(6)]~~ Provider-sponsored integrated health delivery networks shall be subject to the provisions of this subtitle, and to the following provisions of this chapter, to the extent applicable and not in conflict with the expressed provisions of this subtitle:

(a) Subtitle 1 -- Scope of Code;

(b) Subtitle 2 -- Insurance Commissioner;

(c) Subtitle 3 -- Authorization of Insurers and General Requirements;

(d) Subtitle 4 -- Fees and Taxes;

(e) Subtitle 5 -- Kinds of Insurance--Limits of Risk--Reinsurance;

(f) Subtitle 6 -- Assets and Liabilities;

(g) Subtitle 7 -- Investments;

(h) Subtitle 8 -- Administration of Deposits;

(i) ***Subtitle 9 -- Agents, Consultants, Solicitors and Adjuster;***

(j) Subtitle 12 -- Trade Practices and Frauds;

(k)~~[j]~~Subtitle 14 -- KRS ***304.14-120 to 304.14-130 and*** 304.14-500 to 304.14-560;

(l)~~[(k)]~~ Subtitle 25 -- Continuity of Management;

(m)~~[(l)]~~ Subtitle 33 -- Insurers Rehabilitation and Liquidation;

(n)~~[(m)]~~ Subtitle 37 -- Insurance Holding Company Systems; and

(o)~~[(n)]~~ Subtitle 99 -- Penalties.

Section 3. KRS 304.17A-330 is amended to read as follows:

All insurers authorized to write health insurance in this state and employer-organized associations that self-insure shall transmit at least annually by ***July 31***~~[March 30]~~ to the commissioner the following information, in a format prescribed by the commissioner, on their insurance experience in this state for the preceding calendar year:

(1) Total premium by product type and market segment;

(2) Total enrollment by product type and market segment;

(3) Total cost of medical claims filed by product type and market segment;

(4) Total amount of medical claims paid by the insurer ***and insured*** by product type and market segment;

(5) Total policies canceled by type and the aggregate reasons therefor; and

(6) List of total health and medical services paid for, grouped by types of services and costs:

(a) Total cost per health and medical service per insured group~~[per month]~~:

1. Cost paid by insurer;

2. Cost paid by insured; and

(b) ***Number of insureds***~~[Percentage of insured]~~ who received each service.

Section 4. KRS 304.18-120 is amended to read as follows:

(1) A converted policy issued pursuant to the conversion privilege contained in a group policy providing hospital or surgical expense insurance shall ***not impose a lifetime maximum benefit of less than five hundred thousand dollars ($500,000)***~~[provide on an expense incurred basis, the following minimum benefits:~~

~~(a) Hospital room and board benefits of twenty-five dollars ($25) per day, for a minimumduration of seventy (70) days for any one period of hospital confinement as defined in the converted policy;~~

~~(b) Miscellaneous hospital expense benefits for any one (1) period of hospital confinement in a minimum amount up to twenty (20) times the hospital room and board daily benefit provided under the converted policy;~~

~~(c) Surgical operation expense benefits according to a relative value schedule, or aminimum of two hundred fifty dollars ($250); and~~

~~(d) The option to continue any existing benefits on account of pregnancy, childbirth, ormiscarriage]~~.

(2) ***The commissioner by administrative regulation shall establish minimum benefits for a converted policy issued pursuant to the conversion privilege contained in a group health policy.***~~[The relative values in the surgical schedule shall be consistent with the schedule of operations generally offered by the insurer under group or individual health insurance policies. In the event that the insurer and the group policyholder agree upon one (1) or more additional plans of benefits to be available for converted policies, the applicant for the converted policy may, at his option, elect such a plan in lieu of a converted policy providing the benefits of paragraphs (a), (b) and (c) of subsection (1) of this section. In no event shall the benefits be less than the minimums set forth in subsection (1) of this section.~~

(3) ~~In no event need the insurer provide under the converted policy:~~

~~(a) Benefits on account of abortion or complications thereof;~~

~~(b) The benefits of paragraphs (a) and (b) of subsection (1) of this section, unless thegroup policy from which conversion is made provided hospital expense insurance benefits; or~~

~~(c) The benefits of paragraph (c) of subsection (1) of this section, unless the group policyprovided surgical expense insurance benefits. Furthermore, the converted policy may contain any exclusion, reduction, or limitation contained in the group policy and any exclusion, reduction or limitation customarily used in individual policies issued by the insurer. With respect to any person who was covered by the group policy, the period specified in the time limit on certain defenses of the incontestable provision of the converted policy shall commence with the date the insurance on such person or member became effective under the group policy.~~

(4) ~~The converted policy may provide:~~

~~(a) That any hospital, surgical, or medical expense benefits otherwise payable thereunderwith respect to any person covered thereunder may be reduced by the amount of any such benefits payable under the group policy for the same loss with respect to such person after termination of such person's coverage thereunder. The insurer shall not be entitled to use deterioration of health as the basis for refusing to renew a converted policy;~~

~~(b) For termination of coverage thereunder on any person when he is or could be coveredby Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded);~~

~~(c) That the insurer may request information in advance of any premium due date of suchpolicy of any person covered thereunder as to whether:~~

~~1. He is covered for similar benefits by another hospital, surgical or medicalexpense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or~~

~~2. Similar benefits are provided for, or available to, such person pursuant to, or inaccordance with the requirements of, any statute;~~

~~(d) That if any such person is so covered or such statutory benefits are provided oravailable, and such person fails to furnish the insurer the details of such coverage within thirty-one (31) days after the date of such request, the benefits payable under the converted policy may be based on the hospital or surgical or medical expenses actually incurred after excluding expenses to the extent of the amount of benefits provided or available therefor from any of the sources referred to in paragraph (c) of this subsection; and~~

~~(e) For any provisions permitted herein and may also include any other provisions notexpressly prohibited by law; and any provision required to be permitted herein may be made a part of any such policy by means of an endorsement or rider.]~~ Section 5. KRS 304.43-030 is amended to read as follows:

(1) No prepaid dental plan organization shall deliver or issue for delivery in this state any contract describing dental care services available, or any endorsement, rider, or application which becomes a part thereof or any amendment thereto or modification thereof, until a copy of the form or contract or certificate and the schedule of fees or other periodic charges to be paid by the enrollees, has been filed with and approved by the commissioner. Each form, contract, or certificate must contain a complete and clear statement of:

(a) The dental care services to which the enrollee is entitled;

(b) Any limitations on the services, benefits, deductible, or copayments features;

(c) Where and in what manner information is available as to how services may be obtained; and

(d) Any other provisions pertaining to the delivery of the dental care services.

(2) At the expiration of sixty (60) days, the form or contract so filed shall be deemed approved unless it has been previously approved or disapproved by order of the commissioner. The commissioner may withdraw approval at any time with cause.

(3) ***The commissioner shall disapprove any form filed under this section, or withdraw any previous approval thereof, on one (1) or more of the following grounds: (a) If it is in any respect in violation of, or does not comply with, this chapter;***

(b) If it contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract;

(c) If any title, heading, or other indication of its provisions is misleading, or is printed in such size of type or manner of reproduction as to be substantially illegible.

SECTION 6. A NEW SECTION OF SUBTITLE 43 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Each prepaid dental plan issuing dental plan contracts in this state shall, before use thereof, file with the commissioner its premium rates and classification of risks pertaining to such contracts. The prepaid dental plan shall adhere to its rates and classifications as filed with the commissioner.

(2) No filing under Section 2 of this Act that contains an increase in premium rates shall become effective until the commissioner has issued an order approving the filing. The commissioner may schedule a hearing within sixty (60) days after receiving a filing under Section 2 of this Act containing a rate increase, and after the hearing shall issue a final order approving or disapproving the filing.

(3) In approving or disapproving a filing under subsection (2) of this section, the commissioner shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium charged;

(b) Previous premium rates for contracts to which the filing applies;

(c) The effect of the increase on policyholders; and

(d) Whether the prepaid dental plan has computed an enrollee's coinsurance or cost sharing on the basis of the amount actually received by a provider from the prepaid dental plan.

(4) No prepaid dental plan receiving the commissioner's approval of a filing under this section shall submit a new filing containing a rate increase for any of the same contracts until at least six (6) months have elapsed following the effective date of the approved increase.

(5) At any time, the commissioner, after an administrative hearing, may withdraw approval of the rates previously approved under this section if he determines that the benefits are no longer reasonable in relation to the premium charged.

(6) At the expiration of sixty (60) days, the filed premium rates shall be deemed approved unless approved or disapproved by order of the commissioner prior to the expiration of sixty (60) days.

(7) The commissioner may, by administrative regulation, prescribe any additional information related to rates, fees, dues, and other charges deemed necessary and relevant to be included in the filing of forms and rates required by this section.

Section 7. KRS 304.18-110 is amended to read as follows:

(1) As used in this section:

(a) "Group policy" means group health insurance policies as defined in KRS 304.18-020 and blanket health insurance policies which the commissioner, in his discretion, designates as subject to this section, which:

1. Affect the rights of a Kentucky insured and bear a reasonable relation to Kentucky, regardless of whether delivered or issued for delivery in Kentucky;

2. Provide hospital or surgical expenses benefits, other than for a specific disease or accidental injury only; and

3. Are delivered, issued for delivery, or renewed after July 15, 1986;

(b) "Medicare" means Title XVIII of the United States Social Security Act as amended or superseded.

(2) Persons insured under group policies have the right upon termination of group membership to continue coverage for themselves and their dependents upon meeting the following conditions:

(a) The group member has been covered by the group policy or any group policy it replaced for at least three (3) months; and

(b) Notice is given to the insurer and payment of the group rate is made to the insurer within thirty-one (31) days after notice pursuant to subsection (9) of this section.

(3) Continued group health insurance coverage shall terminate on the earlier of:

(a) The date eighteen (18) months after the date on which the group coverage would otherwise have terminated because of termination of group membership;

(b) If the group member fails to make timely payment of premium to the insurance company, the end of the period for which premium payment was made; or

(c) The date the group policy is terminated and is not replaced by another group policy within thirty-one (31) days. ***In the case of replacement coverage as provided in subsection (4) of this section, the replaced policy and insurer shall terminate continued group health coverage in the same manner that coverage is terminated for active employees.***

(4) ***If an employer's group policy is terminated and replaced by a new group policy, subject to the termination provisions contained in subsection (3) of this section, persons under continued group health insurance coverage under the replaced policy at the time of replacement shall be offered continued group health insurance coverage under the subsequent group policy under rules that are no less favorable to the person under continued group coverage than are available to similarly situated eligible employees. This***

subsection shall not be construed to prevent a change in group health coverage so long as the change does not directly discriminate against persons under continued group coverage and continues on the basis of health status-related factors.

(5) ***Nothing in subsection (4) of this section shall be construed to begin a new eighteen (18) months period of continued group health insurance coverage eligibility under paragraph (a) of subsection (3) of this section. This eligibility shall be a continuous period of eighteen (18) consecutive months.*** ~~[If a group policy is replaced, persons under continued group health insurance coverage under the replaced policy shall remain under such coverage under the replaced policy until it terminates pursuant to subsection (3) of this section.]~~

(6) ~~[(5)]~~ Group members have the right upon termination of coverage under a group policy for any reason to have a conversion health insurance policy providing substantially similar benefits issued to the group member by the insurer upon meeting the following conditions:

(a) The group member has been covered by the group policy or any policy it replaced for at least three (3) months;

(b) The group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection ***(10)*** ~~[(9)]~~ of this section; and

(c) The group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection ***(10)*** ~~[(9)]~~ of this section.

(7) ~~[(6)]~~ Terms of conversion health insurance coverage:

(a) Conversion health insurance coverage shall be available without evidence of insurability and shall contain no pre-existing condition limitations;

(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:

1. The effective date of the converted policy; or

2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;

(c) The conversion health insurance policy shall cover the group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated;

(d) The effective date of the conversion health insurance policy shall be the date of termination of coverage under the group policy; and

(e) The conversion health insurance policy shall provide benefits substantially similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120.

(8) ~~[(7)]~~ The right to continue group health insurance coverage and the right to conversion health insurance coverage shall also be available:

(a) To the surviving spouse, at the death of the group member, with respect to the spouse and such children whose coverage under the group policy would terminate or terminates by reason of the death of the group member;

(b) To a child solely with respect to himself upon termination of membership in the group or his coverage by reason of operation of the limiting age of coverage under the group policy while covered as a dependent thereunder; or

(c) To a former spouse for himself and such children of whom he is awarded custody when coverage under the group policy would terminate or terminates by reason of termination of dependency as defined in the group policy and resulting from an order dissolving the marriage entered by a court of competent jurisdiction.

(9) ~~[(8)]~~ Continuation of group health insurance coverage or conversion health insurance coverage need not be granted in the following situations:

(a) The applicant is or could be covered by Medicare;

(b) The applicant is or could be covered by another group coverage (insured or uninsured) or, in the case of conversion health insurance coverage, the applicant is~~[or could be]~~ covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or

(c) In the case of conversion health insurance coverage, the issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection.

(10) ~~[(9)]~~ Notice of the right to continue group health insurance coverage and the right to conversion health insurance coverage shall be given as follows:

(a) 1. For group policies delivered, issued for delivery, or renewed after July 15, 1986, the insurer shall give written notice of the right to continue group health insurance coverage and the right to conversion health insurance coverage to any group member entitled to continue coverage or to conversion coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group or upon termination of continued group health insurance coverage. The thirty-one (31) day period of subsections (2)(b) and ***(6)*** ~~[(5)]~~(b) of this section shall not begin to run until the notice required by this paragraph is mailed or delivered to the last known address of the group member; and

2. Upon replacement of a group policy, the replacing insurer shall determine if there are group members who were covered under the previous group policy who

are not covered under the replacing group policy. The replacing insurer shall by writing notify the insurer which issued the previous group policy of such lack of coverage and the insurer which issued the previous group policy shall issue the notice required by paragraph (a) of this subsection;

(b) If a group member becomes entitled to obtain continued health insurance coverage or conversion health insurance coverage pursuant to this section and if such group member has not been given written notice of these rights pursuant to this subsection, such group

member shall have an additional period within which to exercise continuation or conversion rights as follows:

1. The additional period shall expire fifteen (15) days after the group member is given notice, but in no event shall the additional period extend beyond sixty (60) days after the expiration of the thirty-one (31) day period following termination from the group or termination of group coverage;

2. Written notice delivered or mailed to the last known address of the group member shall constitute the giving of notice for the purpose of this paragraph; and

3. If a group member makes application and pays the premium for continued health insurance coverage or conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of continued health insurance coverage shall be the date of termination from the group and the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage.

(11) ~~[(10)]~~ Before a group policy may be replaced, the employer shall give at least thirty (30) days written notice by certified mail to any employee covered under the replaced policy who will not be covered under the new policy.

Section 8. KRS 304.17A-080 is amended to read as follows:

(1) There is hereby created and established a Health Insurance Advisory Council whose duties shall be to review and discuss with the commissioner any issues which impact the provision of health insurance in the state. The advisory council shall consist of seven (7) members: the commissioner plus six (6) persons appointed by the Governor with the advice of the commissioner to serve two (2) year terms. The commissioner shall serve as chair of the advisory council.

(2) The six (6) persons appointed by the Governor with the advice of the commissioner shall be:

(a) Two (2) representatives of insurers currently offering health benefit plans in the state;

(b) Two (2) practicing health care providers; and

(c) Two (2) representatives of purchasers of health benefit plans.

(3) The council shall:

(a) Review and discuss the design of the standard health benefit plan;

(b) Review and discuss the rate-filing process for all health benefit plans;

(c) Review and discuss the administrative regulations concerning this subtitle to be promulgated by the department;

(d) Make recommendations on high-cost conditions as provided in subsection (5) of this section; and

(e) Review and discuss other issues at the request of the commissioner.

(4) The advisory council shall be a budgetary unit of the department which shall pay all of the advisory council's necessary operating expenses and shall furnish all office space, personnel, equipment, supplies, and technical or administrative services required by the advisory council in the performance of the functions established in this section.

(5) No less than annually, the Health Insurance Advisory Council shall review the list of highcost conditions established by the commissioner under KRS ***304.17A-005(20)*** ~~[304.17A005(19)]~~ and 304.17A-280 and recommend changes to the commissioner. The commissioner may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the commissioner deems appropriate. The council, in making recommendations, and the commissioner, in making changes, shall consider, among other things, actual claims and losses on each diagnosis and advances in treatment of high-cost conditions.

(6) For each calendar year that the Kentucky Guaranteed Acceptance Program is operating, every insurer shall report to the commissioner and the Health Insurance Advisory Council, in the form and at the time as the commissioner by administrative regulation may specify, information that the commissioner deems necessary for the council and commissioner to evaluate the list of high-cost conditions as required under this section.

Section 9. KRS 304.17A-210 is amended to read as follows:

Each insurer that issues health benefit plans in the individual market shall be required to issue health benefit plans in the individual market on a guaranteed-issue basis as follows:

(1) An eligible individual shall be entitled to have coverage issued from the insurer under the standard health benefit plan or any other health benefit plan sold by the insurer in the individual market;

(2) Except as provided in subsection (3) of this section, an individual who has been a resident of Kentucky for at least twelve (12) months shall be entitled to have coverage issued from the insurer under the standard health benefit plan or any other health benefit plan sold by the insurer in the individual market***, except that an individual shall not be eligible for coverage if the individual has, or is eligible for, on the date of application for individual coverage, substantially similar coverage under a group contract or policy. If an individual is ineligible for coverage under this subsection, that individual's spouse or dependents shall not be precluded from eligibility for coverage in the individual market. As used in this subsection, "eligible for" includes any individual who was eligible for group coverage but who waived that coverage. That individual shall be ineligible for coverage in the individual market through the period of waived coverage***; and

(3) Except as provided in subsection (4) of this section, if the individual is a guaranteed acceptance program qualified individual and the insurer is a guaranteed acceptance program participating insurer, then the individual shall be entitled to have coverage issued under either:

(a) The standard health benefit plan; or

(b) The insurer's two (2) health benefit plans, other than the standard health benefit plan, sold by it in the individual market in Kentucky, or in the applicable marketing or service area as may be prescribed by the commissioner by administrative regulation, with the largest annual premium volume; except that the insurer shall make all necessary adjustments to the health benefit plans sold so that they qualify as a guaranteed acceptance program plan and can be included in the guaranteed acceptance program risk adjustment process. During the period of July 1, 1998, to June 30, 1999, the guaranteed acceptance program participating insurer may designate upon approval of the commissioner any health benefit plans made generally available to, and actively marketed in, the individual market as this option. The insurer shall make all necessary

adjustments to the designated health benefit plans so that they qualify as a guaranteed acceptance program plan and can be included in the guaranteed acceptance program risk adjustment process.

(4) If the insurer does not generally operate in the individual market and has elected under KRS 304.17A-420(3)(a) to be a guaranteed acceptance program participating insurer without generally operating in the individual market, then an individual who is a guaranteed acceptance program qualified individual shall be entitled to have coverage issued from that insurer only under the standard health benefit plan.

(5) (a) No insurer, who was not offering health benefit plans in Kentucky on January 1, 1998, shall be required to accept annually under this section individuals who, in the aggregate, would cause the insurer to have a total number of new insureds with highcost conditions as defined in KRS ***304.17A-005(20)***~~[304.17A-005(19)]~~ or which exceed an insurer's underwriting guidelines as approved by the commissioner under KRS 304.17A-430(3)(b) per year that is more than one-half of one per cent (0.5%) of the total number of individuals insured by the insurer under individual health benefits plans issued or issued for delivery in the Commonwealth, calculated as of the immediately preceding thirty-first day of December.

(b) The commissioner shall, by administrative regulation, establish equitable enrollment limits for the first twelve (12) months, and any remaining portion of the calendar year after the expiration of that twelve (12) month period, in which an insurer first begins doing business in the individual market. These limits shall be based on the insurer's quarterly enrollment in health benefit plans offered in the individual market in the Commonwealth.

(c) An officer of the insurer shall certify to the department when it has met the enrollment limit established in this subsection. Upon providing this certification, the insurer shall be relieved of its guaranteed issue requirement under this section for the remainder of the calendar year.

(d) If all insurers that are required to offer coverage on a guaranteed-issue basis meet the enrollment limit established in this subsection prior to the end of the calendar year, then all such insurers shall again accept individuals for guaranteed issue coverage, subject to the enrollment limit established in this subsection.

(e) If certification of the enrollment limit would leave any county in the Commonwealth without an insurer to provide coverage in the individual market, the commissioner may require any insurer that meets the criteria in KRS 304.17A-420(1) to continue to offer coverage in that county. The commissioner shall proportionally increase the enrollment limit under this subsection for all other insurers that do not meet the criteria of KRS 304.17A-420(1).

(6) An insurer that elects to use the alternative underwriting mechanism under KRS 304.17A430(3) shall offer to those insureds who are subject to the alternative underwriting mechanism the standard plan and the two (2) plans offered by the insurer with the largest premium volume for the last calendar year.

(7) For the purposes of this section and KRS 304.17A-250, insurers whose activities in the individual market are limited to the renewal of health benefit plans issued prior to July 15, 1995, shall not be deemed to be doing business in the individual market.

(8) Subsections (1) to (7) of this section shall not apply to a health benefit plan offered by an insurer if the coverage is made available in the individual market only through one (1) or more bona fide associations.

Section 10. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1)

of this section for high risk individuals rather than using the criteria established in KRS ***304.17A-005(20)***~~[304.17A-005(19)]~~ and 304.17A-280 for high cost conditions;

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

Section 11. KRS 304.17-312 is amended to read as follows:

As used in KRS 304.17-313,~~[304.17-410,]~~ 304.18-037, 304.32-280, and 304.38-210:

(1) "Home health agency" means a public agency or private organization, or a subdivision of such an agency or organization which is licensed as a home health agency by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board and is certified to participate as a home health agency under Title XVIII of the Social Security Act.

(2) "Home health care" means the care and treatment provided by a home health agency which is prescribed and supervised by a physician. The care and treatment shall include but not be limited to one (1) or more of the following:

(a) Part-time or intermittent skilled nursing services provided by an advanced registered nurse practitioner, registered nurse, or licensed practical nurse;

(b) Physical, respiratory, occupational, or speech therapy;

(c) Home health aide services;

(d) Medical appliances and equipment, drugs and medication, and laboratory services, to the extent that such items and services would have been covered under the policy if the covered person had been in a hospital.

(3) "Home health aide services" means those services provided by a home health aide and supervised by a registered nurse which are directed towards the personal care of the patient. Such services shall include but not be limited to the following:

(a) Helping the patient with bath, care of mouth, skin, and hair;

(b) Helping the patient to the bathroom or in using a bedpan;

(c) Helping the patient in and out of bed and assisting with ambulation;

(d) Helping the patient with prescribed exercises which the patient and home health aide have been taught by appropriate professional personnel;

(e) Assisting with medication ordinarily self-administered that has been specifically ordered by a physician;

(f) Performing incidental household services as are essential to the patient's health care at home provided that such services would have been performed if the patient was in a hospital or skilled nursing facility; and

(g) Reporting to the professional nurse supervisor changes in the patient's condition or family situation.

Section 12. KRS 18A.229 is amended to read as follows:

(1) State employees as defined in KRS 18A.228 participating in the health insurance fund authorized in KRS 42.805 shall be given at least three (3) alternative plans from which participation may be chosen. One (1) plan shall require no fixed deductible expenses and reasonable co-payment ratios.

(2) State employees whose income is at or below one hundred percent (100%) of the nonfarm income official poverty guidelines as determined by the United States Department of Health and Human Services, may choose health insurance benefits ***that include, but are not limited to, coverage for emergency medical services and basic inpatient hospital services, which shall include at least fourteen (14) days room and board and at least fifty percent (50%) of the related charges for physician's services***~~[described in KRS 304.18-025(2)(c) and (d)]~~.

SECTION 13. A NEW SECTION OF KRS CHAPTER 304.17A-500 TO 304.17A.570 IS CREATED TO READ AS FOLLOWS:

A contract executed after January 1, 2001, between a managed care plan and a physician shall not require the mandatory use of a hospitalist.

Section 14. KRS 304.17A-095 is amended to read as follows:

(1) ***(a)*** Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan ***to any market segment other than a large group*** shall, before use thereof, file with the commissioner its rates, fees, dues, and other charges paid by insureds, members, enrollees, or subscribers, shall submit a copy of the filing to the Attorney General, and shall comply with the provisions of this section. The insurer shall adhere to its rates, fees, dues, and other charges as filed with the commissioner. The insurer may submit new filings from time to time as it deems proper.

(b) Notwithstanding any other provisions of this chapter to the contrary, each insurer that issues, delivers, or renews any health benefit plan to a large group as defined in KRS 304.17A-005 shall file the rating methodology with the commissioner and shall submit a copy of the filing to the Attorney General.

(2) (a) A rate filing under this section may be used by the insurer on and after the date of filing with the commissioner prior to approval by the commissioner. A rate filing shall be approved or disapproved by the commissioner within sixty (60) days after the date of filing. Should sixty (60) days expire after the commissioner receives the filing before approval or disapproval of the filing, the filing shall be deemed approved. The commissioner may hold a hearing within sixty (60) days after receiving a filing

containing a rate increase. Not less than thirty (30) days in advance of a hearing held under this section, the commissioner shall notify the Attorney General in writing of the hearing. The Attorney General may participate as a health insurance consumer intervenor and be considered a party to the hearing.

(b) The commissioner shall hold a hearing upon written request, including the reasons for the request, by the Attorney General, provided the request is in accordance with subsection (3) of this section.

(c) The commissioner shall hold a hearing, unless waived by the health insurer, before ordering a retroactive reduction of rates.

(d) The hearing shall be a public hearing conducted in accordance with KRS Chapter 13B.

(e) In the circumstances of a filing that has been deemed approved under paragraph (a) of this subsection, the commissioner shall have the authority to order a retroactive reduction of rates to a reasonable rate if after applying the factors in subsection (3) of this section the commissioner determines that the rates were unreasonable. If the commissioner seeks to order a retroactive reduction of rates and more than one (1) year has passed since the date of the filing, the commissioner shall consider the reasonableness of the rate over the entire period during which the filing has been in effect.

(3) In approving or disapproving a filing under this section, the commissioner shall consider:

(a) Whether the benefits provided are reasonable in relation to the premium or fee charged;

(b) Whether the fees paid to providers for the covered services are reasonable in relation to the premium or fee charged;

(c) Previous premium rates or fees for the policies or contracts to which the filing applies;

(d) The effect of the rate or rate increase on policyholders, enrollees, and subscribers;

(e) Whether the rates, fees, dues, or other charges are excessive, inadequate, or unfairly discriminatory; and

(f) The effect on the rates of any assessment made under KRS 304.17A-460; and (g) Other factors as deemed relevant by the commissioner.

(4) The rates for each policyholder shall be guaranteed for twelve (12) months at the rate in effect on the date of issue or date of renewal.

(5) At any time the commissioner, after a public hearing for which at least thirty (30) days' notice has been given, may withdraw approval of rates or fees previously approved under this section and may order an appropriate refund or future premium credit to policyholders, enrollees, and subscribers if the commissioner determines that the rates or fees previously approved are in violation of this chapter.

(6) Each insurer paying a risk assessment under KRS 304.17A-460 may include the amount of the assessment in establishing premium rates filed with the commissioner under this section. The insurer shall identify any assessment allocated.

(7) The commissioner may by administrative regulation prescribe any additional information related to rates, fees, dues, and other charges as they relate to the factors set out in subsection (3) of this section that he or she deems necessary and relevant to be included in the filings and the form of the filings required by this section. Section 15. KRS 304.17A-150 is amended to read as follows:

(1) On and after July 15, 1995, it is an unfair trade practice for an insurer, agent, broker, or any other person in the business of marketing and selling health plans, to commit or perform any of the following acts:

(a) Encourage individuals or groups to refrain from filing an application for coverage with the insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(b) Encourage or direct individuals or groups to seek coverage from another insurer because of the individual's or group's health status, claims experience, industry, occupation, or geographic location; or

(c) Encourage an employer to exclude an employee from coverage.

The provisions of paragraphs (a) and (b) of this subsection shall not apply to information provided regarding the established geographic service area of an insurer.

(2) It is an unfair trade practice for an insurer to compensate an agent, broker, or any other person in the business of marketing and selling health plans on the basis of the health status, claims experience, industry, occupation, or geographic location of the insured or prospective insured.

(3) It shall constitute an unfair trade practice for any insurer, insurance agent, or third-party administrator to refer an individual employee to the Kentucky guaranteed acceptance program or to arrange for an individual employee to apply to that plan, for the purpose of separating an employee from group health insurance coverage provided in connection with the individual's employment.

(4) ***It is an unfair trade practice for an insurer that offers multiple health benefit plans to require a health care provider, as a condition of participation in a health benefit plan of the insurer, to participate in any of the insurer's other health benefit plans. In addition to the proceedings and penalties provided in this chapter for violation of this provision, a contract provision violating this subsection is void.***

(5) It is an unfair trade practice for an insurer not to compute an insured's coinsurance or cost sharing on the basis of the amount actually received by a health-care provider from the insurer.

(6) ~~[(5)]~~ The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment under KRS 304.17A-470. As an alternative, the commissioner may levy a civil penalty on any member insurer that fails to pay the assessment when due. The civil penalty shall not exceed five percent (5%) of the unpaid assessment per month, but no civil penalty shall be less than one hundred dollars ($100) per month.

(7) ~~[(6)]~~ The remedy provided by KRS 304.12-120 shall be available for conduct proscribed by this section.

(8) It is an unfair claims settlement practice for any person to make claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made in instances in which the insured has a liability under the policy beyond his or her copayment or deductible.

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

(1) An insurer may delay payment by contesting a clean claim only in the following instances:

(a) The insurer has information that another insurer is primarily responsible for the claim;

(b) The insurer will conduct a retrospective review of the services identified on the claim;

(c) The insurer has information that the claim was submitted fraudulently; or (d) The covered person's or group's premium has not been paid.

(2) (a) If an insurer routinely requires a provider to submit attachments to the claim containing additional medical information summarizing the diagnosis, the treatment, or services rendered to the covered person before the claim will be paid, the insurer shall identify the specific routinely required information in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide sixty (60) days' advance written notice of modifications to the provider manual that materially change the type or content of the attachments to be submitted;

(b) If a provider submits a clean claim with the required attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in this subtitle; and

(c) If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall:

1. Notify the provider, in writing or electronically within the claims payment time frame established in this subtitle, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim;

2. Complete the retrospective review within twenty (20) business days of the insurer's receipt of the medical information described in this subsection; and

3. Add interest to the amount of the claim to be paid at a rate of twelve percent (12%) per annum, or at a rate in accordance with this subtitle accruing from the thirty-first day after the claim was received by the insurer through the date upon which the claim is paid.

(3) (a) If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, the insurer shall, within the applicable claims payment time frame established in this subtitle, provide written or electronic notice to the provider, covered person, or insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed; and

(b) The insurer shall pay or deny the claims within thirty (30) calendar days of receiving the additional information described in paragraph (a) of this subsection.

Section 17. KRS 304.17A-545 as amended by House Bill 525 of the 2000 Regular Session, if that bill becomes law, is further amended to read as follows: (1) A managed care plan shall appoint a medical director who:

(a) Is a physician licensed to practice in this state;

(b) Is in good standing with the State Board of Medical Licensure;

(c) Has not had his or her license revoked or suspended, under KRS 311.530 to 311.620;

(d) Shall sign any ***denial letter required under KRS 304.17A-540***~~[decision to deny any health care benefit]~~; and

(e) Shall be responsible for the treatment policies, protocols, quality assurance activities, and utilization management decisions of the plan.

(2) The medical director shall ensure that:

(a) Any utilization management decision to deny, reduce, or terminate a health care benefit or to deny payment for a health care service because that service is not medically necessary shall be made by a physician, except in the case of a health care service rendered by a chiropractor or optometrist, that decision shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky;

(b) A utilization management decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person or the participating provider;

(c) In the case of a managed care plan, a procedure is implemented whereby participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and whereby other participating providers have an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice;

(d) The utilization management program is available to respond to authorization requests for urgent services and is available, at a minimum, during normal working hours for inquiries and authorization requests for nonurgent health care services; and

(e) In the case of a managed care plan, a covered person is permitted to choose or change a primary care provider from among participating providers in the provider network and, when appropriate, choose a specialist from among participating network providers following an authorized referral, if required by the insurer, and subject to the ability of the specialist to accept new patients.

(3) A managed care plan shall develop comprehensive quality assurance or improvement standards adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of health care services. These standards shall be made available to the public during regular business hours and include:

(a) An ongoing written, internal quality assurance or improvement program;

(b) Specific written guidelines for quality of care studies and monitoring, including attention to vulnerable populations;

(c) Performance and clinical outcomes-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action; (e) A plan for data gathering and assessment; and (f) A peer review process.

(4) Each managed care plan shall have a process for the selection of health care providers who will be on the plan's list of participating providers, with written policies and procedures for review and approval used by the plan.

(a) The plan shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state;

(b) The plan shall demonstrate that it has consulted with appropriately qualified health care providers to establish the minimum professional requirements;

(c) The plan's selection process shall include verification of each health care provider's license, history of license suspension or revocation, and liability claims history;

(d) A managed care plan shall establish a formal written, ongoing process for the reevaluation of each participating health care provider within a specified number of years after the provider's initial acceptance into the plan. The reevaluation shall include an update of the previous review criteria and an assessment of the provider's performance pattern based on criteria such as enrollee clinical outcomes, number of complaints, and malpractice actions.

(5) A managed care plan shall not use a health care provider beyond, or outside of, the provider's legally authorized scope of practice.

Section 18. KRS 507.040 is amended to read as follows:

(1) A person is guilty of manslaughter in the second degree when~~[, including, but not limited to, the operation of a motor vehicle,]~~ he wantonly causes the death of another person***, including, but not limited to, situations where the death results from the person's:***

(a) Operation of a motor vehicle; or

(b) Leaving a child under the age of eight (8) years in a motor vehicle under circumstances which manifest an extreme indifference to human life and which create a grave risk of death to the child, thereby causing the death of the child.

(2) Manslaughter in the second degree is a Class C felony.

Section 19. KRS 165.160 is amended to read as follows:

(1) Cities of the second***, third, and fourth classes***~~[class]~~ may establish or acquire by lawful conveyance municipal colleges for the purpose of promoting public education. A college in a city of the second***, third, or fourth*** class shall not constitute a municipal college or receive support as provided in KRS 165.170 to 165.190 unless it is controlled by a board of trustees appointed by the mayor and legislative body of the city, and unless its principal work is the maintenance of courses affording instruction in such arts, sciences and professions and conferring such certificates of attainment as are authorized by other similar institutions of learning above the high school grade. No advisory board shall be appointed for any college established pursuant to the provisions of this section, and the board of trustees of the college shall perform the functions of an advisory board in addition to its other functions.

(2) If the college is supported by a municipal college support district, three (3) members of the board of trustees mentioned in subsection (1) shall be appointed by the governing body of the district.

Section 20. KRS 165.165 is amended to read as follows:

The legislative body of a city of the second***, third, or fourth*** class in which a municipal college or junior college exists under the provisions of KRS 165.160 to 165.260 may, for educational purposes, use and employ all the authority contained in KRS 165.080 to 165.140 and 162.340 to 162.380 to issue bonds for the benefit of such college.

Section 21. KRS 165.180 is amended to read as follows:

Any city of the second***, third, or fourth*** class having a municipal college may devote to college purposes any funds or properties derived from sources other than taxes levied for special purposes.

Section 22. KRS 165.190 is amended to read as follows:

The legislative body of any city of the second***, third, or fourth*** class may appropriate as a site for the buildings and grounds for a municipal college any public grounds of the city not especially appropriated or dedicated to any other use.

Section 23. KRS 165.195 is amended to read as follows:

The board of trustees of a municipal college in a city of the second***, third, or fourth*** class may acquire, by purchase or gift, lands and improvements for the purpose of expanding the plant and extending the usefulness of the college, and when unable to agree with the owner of land and improvements necessary for the purposes of the college may proceed to condemn the land and improvements. The condemnation proceedings shall be conducted in the manner provided in the Eminent Domain Act of Kentucky.

SECTION 24. A NEW SECTION OF KRS CHAPTER 165 IS CREATED TO READ AS FOLLOWS:

It shall be a public purpose for a city of any class to support postsecondary education through the appropriation of funds for postsecondary educational facilities located or to be located within the city and for postsecondary educational programs offered within the city. Nothing in Sections 19 to 24 of this Act shall create an obligation or liability for the Council on Postsecondary Education.

SECTION 25. A NEW SECTION OF KRS CHAPTER 164 IS CREATED TO READ AS FOLLOWS:

(1) The "Lung Cancer Research Fund" is created and shall receive funds each year from the tobacco settlement agreement fund created in KRS 248.654 in the amount specified in subsection (5)(b) of Section 2 of House Bill 517 as enacted at the 2000 Regular Session of the General Assembly. The lung cancer research fund shall be used to finance the Lung Cancer Research Project described in subsection (5) of this section. No revenues from the lung cancer research fund shall be allocated until the board has adopted the strategic plan described in subsections (5) and (6) of this section.

(2) A research consortium between the University of Kentucky and the University of Louisville is created and shall be known as the Governance Board of the Lung Cancer Research Project. The consortium shall be attached to the Council on Postsecondary Education for administrative purposes.

(3) The board shall consist of nine (9) members appointed by the Governor as follows:

(a) Two (2) members shall be from the faculty of the School of Medicine at the University of Kentucky;

(b) Two (2) members shall be from the faculty of the School of Medicine at the University of Louisville;

(c) Two (2) members shall be from the Council on Postsecondary Education; and

(d) Three (3) members shall be from the state at large, one (1) of whom shall be appointed chair by the Governor.

(4) Except as provided in paragraphs (a) to (d) of this subsection, the terms of the members shall be for four (4) years and until their successors are appointed and confirmed. A vacancy on the board shall be filled for the remainder of the unexpired term in the same manner as the original appointment. Members may be reappointed. The initial appointments shall be for staggered terms, as follows: (a) Two (2) members shall be appointed for one (1) year;

(b) Two (2) members shall be appointed for two (2) years;

(c) Two (2) members shall be appointed for three (3) years;

and (d) Three (3) members shall be appointed for four (4) years.

(5) The Governance Board of the Lung Cancer Research Project shall develop and oversee the implementation of a twenty (20) year strategic plan that utilizes the resources of both the University of Louisville and the University of Kentucky in establishing the Lung Cancer Research Project. The Lung Cancer Research Project shall be a joint program to:

(a) Develop an expertise in the area of lung cancer research with an immediate focus on early detection and epidemiology and with an ultimate goal of eradication of lung cancer;

(b) Establish a statewide clinical trial network to make university-based clinical trials available to the community physician in order to bring the most innovative cancer treatments to all Kentuckians in need of these treatments;

(c) Leverage the resources earmarked for the Lung Cancer Research Project toward the certification of the cancer program at the University of Kentucky and the University of Louisville by the National Cancer Institute as a cancer center; and (d) Undertake other initiatives consistent with the strategic plan.

(6) The strategic plan shall identify both short-term and long-term goals and the appropriate oversights to measure progress toward achievement of those goals; it shall be updated every two (2) years.

(7) The Governance Board of the Lung Cancer Research Project shall submit an annual report to the Governor and the Legislative Research Commission by September 1 each year for the preceding fiscal year, outlining its activities and expenditures.

(8) The Auditor of Public Accounts, on an annual basis, shall conduct a thorough review of all expenditures from the lung cancer research fund and, if necessary in the opinion of the Auditor, the operations of the Lung Cancer Research Project and the lung cancer research fund.

Section 26. KRS 205.5632 is amended to read as follows:

(1) No prior authorization shall be required for reimbursement of any claim involving any Medicaid-covered new drug that is available after July 15, 1998, for a period of at least twelve (12) months, during which time the Drug Management Review Advisory Board may review the product.

(2) The Department for Medicaid Services shall promulgate administrative regulations in accordance with KRS Chapter 13A for the drug submission program. Prior to implementation of the administrative regulations, the Drug Management Review Advisory Board shall review the guidelines.

(3) The Department for Medicaid Services shall, within twenty-four (24) months of July 15, 1998, analyze drug class reviews of all current drugs requiring prior authorization, and shall continue requiring prior authorization by using drug class reviews, safety, utilization factors, and unusual or extreme cost drivers having inappropriate economic impact on the Department for Medicaid Services, until the review criteria are promulgated by administrative regulations according to KRS Chapter 13A, and pursuant to KRS 205.5634(2). At least fifty percent (50%) of class reviews shall be completed within twelve (12) months of July 15, 1998.

(4) ***(a) Federal Food and Drug Administration (FDA) approved prescription drugs that have been determined to be within the same pharmacological category, and that have comparable clinical application, efficacy, and safety, and that are of comparable cost to other FDA-approved prescription drugs that have been placed on the Kentucky Medicaid nonprior-authorized drug file shall be placed on the Kentucky Medicaid nonprior-authorized drug file. Any drug that is removed from prior authorization in accordance with the provisions of this section shall be returned to prior authorization status if the comparable drug that was nonpriorauthorized subsequently becomes prior authorized. To assure the cost effective operation of the Medicaid pharmacy program, the department shall file, no later than October 1, 2000, administrative regulations in accordance with KRS Chapter 13A that describe the process that will be employed to describe drug comparability with regard to efficacy, safety, and cost.***

(b) For purposes of this subsection, "pharmacological category" means a category of drugs that is characterized as having very similar properties and therapeutic effects upon living organisms.

SECTION 27. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "adult day health care program" means a program licensed by the Cabinet for Health Services that provides organized health care for its clients during specified daytime hours, that may include continuous supervision to assure that health care needs are being met, supervision of self-administration of medications, and provision of nursing services, personal care services, self-care training, and social and recreational activities for individuals of all ages.

(2) The cabinet shall promulgate administrative regulations in accordance with KRS Chapter 13A to establish health, safety, and treatment requirements for licensed adult day health care programs. No person, association, corporation, or other organization shall operate or maintain an adult day health care program without first obtaining a license as provided in this section.

(3) The cabinet may issue a license upon request to any adult day health care program meeting the standards required under subsection (2) of this section and administrative regulations promulgated thereunder. The cabinet may deny, revoke, suspend, or modify an adult day health care program license for failure to comply with standards set by the cabinet.

(4) Services provided in an adult day health care program for its clients may include: (a) Medical therapeutic services; and (b) Physical and speech therapy.

Section 28. KRS 205.561 is amended to read as follows:

(1) The cabinet shall submit an annual report to the Governor and the Legislative Research Commission on the dispensing of prescription medications to persons eligible under KRS 205.560, on or before ***December***~~[September]~~ 1 of ***each***~~[the]~~ year. ***Each***~~[Such]~~ report shall include ***a research study to determine the average cost of dispensing prescription medications***~~[an estimate of the current cost to pharmacies]~~, including associated administrative costs, ***and the average cost of acquiring drugs for***~~[of dispensing prescription medications to]~~ eligible recipients under the provisions of KRS 205.560, the current level of dispensing fee provided by the cabinet, and an estimate of~~[additional]~~ revenues required to adequately adjust reimbursement to cover costs for~~[such]~~ pharmacies. The report shall also include current data on the most utilized and abused drugs in Medicaid, a determination of factors causing high drug costs and drug usage rates of Medicaid recipients, objectives and timelines for cost containment in the Medicaid drug program, comparative data from other states, and cost effectiveness of the drug formulary and prior authorization process. The annual report shall be developed with the advice of the Drug Management Review Board created under KRS 205.5636.

(2) Prior to data collection and analysis of any research study to determine the cost of dispensing prescription medications and the cost of acquiring drugs for Medicaid eligible recipients, the Cabinet for Health Services and any person or entity holding a contract to perform the study shall report to the Interim Joint Committee on Health and Welfare regarding the proposed research methodology for carrying out subsection (1) of this section.

(3) Any research study to determine the cost of dispensing prescription medications and the cost of acquiring drugs for Medicaid eligible recipients shall include the following components:

(a) Recent academic review of the literature, previous research performed for the Department for Medicaid Services, and research from other states to determine the relevant factors or characteristics to include in the study;

(b) Analysis of relevant factors or characteristics that influence dispensing and acquisition costs including, but not limited to:

1. Urban versus rural location;

2. Chain versus independent affiliation;

3. Total prescription volume; and

4. Medicaid volume as a percent of the total volume;

(c) Sufficient representative sample appropriately stratified to make valid estimates of the effects of each of the relevant factors on dispensing and acquisition costs;

(d) Standard error for each estimate;

(e) Calculation of a ninety-five percent (95%) confidence interval for each sample estimate;

(f) Reports of statistical tests of significance at the five percent (5%) significance level to determine if the variation in dispensing and acquisition costs occur across the stratification types included in the study;

(g) Reports of test results for normality;

(h) Reports of methods to identify and exclude outliers; and

(i) Analysis of the cost of administering the prior authorization program by the Department for Medicaid Services and factors which cause a discrepancy between the cost of dispensing prescription medications and the cost of acquiring drugs for Medicaid eligible recipients as compared to the cost of dispensing prescription medications and acquiring drugs for patients within the commercial market.

(4) The findings of any research study and the annual report required under this section shall be used to establish the fees for dispensing prescription medications to Medicaid eligible recipients. The dispensing fees shall reflect the average cost of dispensing prescription medications to Medicaid eligible recipients in accordance with the annual report.

Section 29. KRS 205.6316 is amended to read as follows:

The Cabinet for Health Services shall review the procedures for medical assistance reimbursement of pharmacists to reduce fraud and abuse. The cabinet shall by promulgation of administrative regulation, pursuant to KRS Chapter 13A, establish the following:

(1) Point-of-sale computer technology, with integration of data at the physician's office and the pharmacy, that will permit prospective drug utilization review;

(2) Usage parameters by drug class to enable medical necessity and appropriateness reviews to be conducted prior to payment;

(3) A dialog among the Department for Medicaid Services, the Kentucky Medical Board of Licensure, and the Kentucky Board of Pharmacy, to develop recommendations for legislation for the 1996 Regular Session of the General Assembly that will strengthen the generic substitution laws for prescription medication; ***and***

(4) A dispensing fee for each prescription in accordance with the findings of the ***annual*** report submitted by the cabinet pursuant to KRS 205.561.

Section 30. The following KRS sections are repealed:

147A.130 Fee to cover administrative costs of health care trusts -- Referral fees prohibited.
304.17-410 Department to collect data concerning cost of health insurance -- Report to General Assembly.

304.18-025 Health care trust.

304.18-055 Pooling of claims experience required.

Approved April 25, 2000