CHAPTER 253

(HB 418)

AN ACT relating to health benefit plans.

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) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

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

(6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(7) "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;

(8) (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***, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service***;

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***, such as the Federal Employees Health Benefit Program***;

9. A public health plan ***as established or maintained by a state, the United States Government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the 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))***; or***

11. Title XXI of the Social Security Act such as State Children's Health Insurance Program.

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection ***(14)***~~[(11)]~~ of this section;

(9) ***"Dependent" means any individual who is or may become eligible for coverage under the terms of an individual or group health benefit plan because of a relationship to a participant;***

(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;

(11) "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;

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

(a) Any entity that was qualified by the executive director 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 employer-organized association shall be treated as an association, small group, or large group under this subtitle;

(13)~~[(11)]~~ "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;

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

(a) Coverage only for accident, ***including accidental death and dismemberment,*** 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; ***and***

(q) Health flexible spending arrangements;

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

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) ~~[(14)]~~ "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 under KRS 304.17A-400 to 304.17A-480;

(18) ~~[(15)]~~ "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 under KRS 304.17A-400 to 304.17A-480;

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

(20) ~~[(17)]~~ "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(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 KRS 304.17A-210(2); 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;

(21) ~~[(18)]~~ "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(22) ~~[(19)]~~ "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, or limited health service benefit plans;

(23) ~~[(20)]~~ "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) Advanced registered nurse practitioners licensed under KRS Chapter 314; and

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

(24) ~~[(21)]~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the executive director 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 executive director under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The executive director 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 executive director, the scoring scale for which shall be established by the executive director.

(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;

(25) ~~[(22)]~~ "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;

(26) ~~[(23)]~~ "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan***. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws***;

(27) ~~[(24)]~~ "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;

(28) ~~[(25)]~~ "Insurer-controlled" means that the executive director 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;

(29) ~~[(26)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

(30) ~~[(27)]~~ "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;

(31) ~~[(28)]~~ "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;

(32) ~~[(29)]~~ "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;

(33) "Participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of the employer or members of the organization, or whose beneficiaries may be eligible to receive any benefit as established in section 3(7) of ERISA;

(34) ~~[(30)]~~ "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

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

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

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

(38) ~~[(34)]~~ "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;

(39) ~~[(35)]~~ "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;

(40) ~~[(36)]~~ "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;

(41) ~~[(37)]~~ "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;

(42) ~~[(38)]~~ "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;

(43) ~~[(39)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) ~~[(40)]~~ "Telehealth" has the meaning provided in KRS 311.550.

Section 2. KRS 304.17A-220 is amended to read as follows:

(1) All group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with the provisions of this section.

(2) Subject to subsection ***(8)*** ~~[(5)]~~ of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a pre-existing condition exclusion only if:

(a) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date***. For purposes of this paragraph:***

1. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and

2. The six (6) month period ending on the enrollment date begins on the six (6) month anniversary date preceding the enrollment date;

(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;~~[and]~~

(c) ***1.*** The period of ***any***~~[that]~~ pre-existing condition exclusion ***that would otherwise apply to an individual*** is reduced by the ***number of days***~~[aggregate of the periods]~~ of creditable coverage ***the individual has***~~[applicable to the participant or beneficiary]~~ as of the enrollment date***, as counted under subsection (3) of this section; and***

2. Except for ineligible individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and

(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.

(3) ***In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. For purposes of counting creditable coverage:***

(a) If on a particular day the individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day;

(b) Any days in a waiting period for coverage are not creditable coverage;

(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and

(d) Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.

(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or evidence of creditable coverage.

(6) For purposes of this section:

(a)~~[1.]~~ "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the ***effective*** date of~~[enrollment for that]~~ coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that ***day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan***~~[date; and~~

~~2. Genetic information shall not be treated as a condition described in subparagraph 1. of this paragraph in the absence of a diagnosis of the condition related to this information]~~;

(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the ***first day of coverage or, if there is a waiting period***~~[date of enrollment of the individual in the plan or coverage or, if earlier]~~, the first day of the waiting period***. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change***~~[for such enrollment]~~;

(c) ***"First day of coverage" means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;***

(d) "Late enrollee" means an individual whose enrollment in a plan is a late enrollment;

(e) "Late enrollment" means enrollment of an individual under a group health plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

2. Through special enrollment[~~"Late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during:~~

~~1. The first period in which the individual is eligible to enroll under the plan; or~~

~~2. A special enrollment period under subsection (7) of this section~~];[~~ and~~]

(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable coverage; and

(g)[~~(d)~~] "Waiting period" means[~~, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan,~~] the period that must pass[~~ with respect to the individual~~] before ***coverage for an employee or dependent who is otherwise eligible to enroll***[~~the individual is eligible to be covered for benefits~~] under the terms of ***a group health***[~~the~~] plan ***can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:***

1. If the application results in coverage, the date coverage begins; or

2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.

(7)[~~(4)(a) A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after the period and before the enrollment date, there was a sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.~~

~~(b) For purposes of paragraph (a) of this subsection and subsection (5)(d) of this section, any period that an individual is in a waiting period for any coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in subsection (8)(b) of this section, shall not be taken into account in determining the continuous period under paragraph (a) of this subsection.~~]

(a)[~~(c)~~] 1. Except as otherwise provided under ***subsection (3) of this section***[~~paragraph (b) of this subsection~~], for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section based on coverage of benefits within each of several classes or categories of benefits specified in ***federal*** regulations[~~ rather than as provided under paragraph (a) of this subsection~~]. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.

3. In the case of an election with respect to a group health plan under ***subparagraph 2.***[~~paragraph (b)~~] of this ***paragraph***[~~subsection~~], whether or not health insurance coverage is provided in connection with the plan, the plan shall:

a. Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made this election; and

b. Include in these statements a description of the effect of this election.

(b)[~~(d)~~] Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection ***(9)***[~~(6)~~] of this section or in such other manner as may be specified in administrative regulations.

(8)[~~(5)~~] (a) Subject to paragraph ***(e)***[~~(d)~~] of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion ***on a child***[~~in the case of an individual~~] who, ***within***[~~as of the last day of the~~] thirty (30) ***days after***[~~day~~]

~~period beginning with the date of~~] birth, is covered under ***any*** creditable coverage. ***If a child is enrolled in a group health plan, or other creditable coverage, within thirty (30) days after birth, and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child.***

(b) Subject to paragraph ***(e)***[~~(d)~~] of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion ***on***[~~in the case of~~] a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, ***within***[~~as of the last day of the~~] thirty (30) ***days after***[~~day period beginning on the date of~~] the adoption or placement for adoption, is covered under ***any*** creditable coverage. ***If a child is enrolled in a group health plan, or other creditable coverage, within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child. This***[~~The previous sentence~~] shall not apply to coverage before the date of the adoption or placement for adoption.

(c) A group health plan[~~, and health insurance insurer offering group health insurance coverage,~~] may not impose any pre-existing condition exclusion relating to pregnancy[~~as a pre-existing condition~~].

(d) ***A group health plan may not impose a pre-existing condition exclusion relating to a condition based solely on genetic information. If an individual is diagnosed with a condition, even if the condition relates to genetic information, the insurer may impose a pre-existing condition exclusion with respect to the condition, subject to other requirements of this section;***

(e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.

(9)[~~(6)~~] (a) 1. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide ***a certificate of creditable coverage as***[~~the certification~~] described in subparagraph 2. of this subsection***. A certificate of creditable coverage shall be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the following events***:

a. At the time an individual ceases to be covered under ***a health benefit***[~~the~~] plan or otherwise becomes ***eligible***[~~covered~~] under a COBRA continuation provision;

b. In the case of an individual becoming covered under ***a COBRA continuation***[~~that~~] provision, at the time the individual ceases to be covered under the ***COBRA continuation*** provision; and

c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision a. or b. of this subparagraph, whichever is later.

The ***certificate of creditable coverage as described***[~~certification~~] under subdivision a. of this subparagraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

2. The certification described in this subparagraph is a written certification of:

a. The period of creditable coverage of the individual under the ***health benefit*** plan and the coverage, if any, under the COBRA continuation provision; and

b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.

(b) In the case of an election described in subsection (4)(c)2. of this section by a group health plan or health insurance insurer, if the plan or insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (a) of this subsection:

1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or insurer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.

(10) ~~[(7)]~~ (a) A group health plan, and a health insurance insurer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan, or a dependent of that employee if the dependent is eligible, but not enrolled, for coverage under these terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, ***cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child,*** death ***of employee***, termination of employment,~~[or]~~ reduction in the number of hours of employment,~~[or]~~ employer contributions toward the coverage were terminated***, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual***; ***or***~~[and]~~

c. Was offered through a health maintenance organization, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

4. ***An insurer shall allow an employee and dependent a period of at least thirty (30) days after an event described in this paragraph has occurred to request enrollment for the employee or the employee's dependent. Coverage shall begin no later than the first day of the first calendar month beginning after the date the insurer receives the request for special enrollment***~~[Under the terms of the plan, the employee requests the enrollment not later than thirty (30) days after the date of exhaustion of coverage described in subparagraph 3.a. of this paragraph or termination of coverage or employer contribution described in subparagraph 3.b. of this paragraph]~~.

(b) ***A dependent of a current employee, including the employee's spouse, and the employee each are eligible for enrollment in the group health plan subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee if the requirements of paragraph (a) of this subsection are satisfied.***

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

the group health plan shall provide for a dependent special enrollment period described in subparagraph 2. of this paragraph during which the person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

2. A dependent special enrollment period under this subparagraph shall be a period of ***at least*** ~~[not less than]~~ thirty (30) days and shall begin on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the coverage of the dependent shall become effective:

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

(11) ~~[(8)]~~ (a) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health status-related factors; and

3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

(b) 1. For purposes of this section, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

2. This period shall begin on the enrollment date.

3. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(c) A health maintenance organization described in paragraph (a) of this subsection may use alternative methods other than those described in that paragraph to address adverse selection as approved by the executive director.

Section 3. KRS 304.17A-230 is amended to read as follows:

(1) A health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth shall not impose any pre-existing conditions exclusions as to any eligible individual.

(2) Each health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth that chooses to impose a pre-existing conditions exclusion on individuals who do not meet the definition of eligible individual shall comply with the provisions of KRS 304.17A-220, which establishes standards and requirements for pre-existing conditions exclusions for group health plans, including crediting previous coverage, and certification of coverage~~[; except the period of creditable coverage shall only reduce the period of a pre-existing condition exclusion in a policy that has benefits substantially similar to the benefits provided in the creditable coverage]~~. Pregnancy may be considered to be a pre-existing condition.

(3) Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the information.

(4) The Office of Insurance shall promulgate administrative regulations necessary to carry out the provisions of Sections 2 and 3 of this Act.

Section 4. KRS 304.17A-096 is amended to read as follows:

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group, and employer-organized association markets. A basic health benefit plan shall cover physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist.

(2) An insurer that offers a basic health benefit plan shall be required to offer health benefit plans as defined in KRS 304.17A-005***(22)***~~[(19)]~~.

(3) An insurer in the individual, small group, or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health benefit plan shall include coverage for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), and chiropractic benefits as provided in KRS 304.17A-171, and those mandated benefits specified under federal law.

(4) Notwithstanding any other provisions of this section, mandated benefits excluded from coverage shall not be deemed to include the payment, indemnity, or reimbursement of specified health care providers for specific health care services.

Section 5. 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***(24)*** ~~[(21)]~~ 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 executive director. Before the insurer may implement the mechanism, the insurer shall obtain approval of the executive director. Annually thereafter, the insurer shall obtain the executive director's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

Section 6. KRS 304.17B-001 is amended to read as follows:

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

(1) "Administrator" is defined in KRS 304.9-051(1);

(2) "Agent" is defined in KRS 304.9-020;

(3) "Assessment process" means the process of assessing and allocating guaranteed acceptance program losses or Kentucky Access funding as provided for in KRS 304.17B-021;

(4) "Authority" means the Kentucky Health Care Improvement Authority;

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

(6) "Executive director" is defined in KRS 304.1-050(1);

(7) "Office" is defined in KRS 304.1-050(2);

(8) "Earned premium" means the portion of premium paid by an insured that has been allocated to the insurer’s loss experience, expenses, and profit year to date;

(9) "Enrollee" means a person who is enrolled in a health benefit plan offered under Kentucky Access;

(10) "Eligible individual" is defined in KRS 304.17A-005***(11)*** ~~[(9)]~~;

(11) "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(12) "Guaranteed acceptance program participating insurer" means an insurer that offered health benefit plans through December 31, 2000, in the individual market to guaranteed acceptance program qualified individuals;

(13) "Health benefit plan" is defined in KRS 304.17A-005***(22)*** ~~[(19)]~~;

(14) "High-cost condition" means 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's 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, Wilson's disease, chronic renal failure, malignant neoplasm of the trachea, malignant

neoplasm of the bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation period for a newborn child, and low birth weight of a newborn child;

(15) "Incurred losses" means for Kentucky Access the excess of claims paid over premiums received;

(16) "Insurer" is defined in KRS 304.17A-005***(27)*** ~~[(24)]~~;

(17) "Kentucky Access" means the program established in accordance with KRS 304.17B-001 to 304.17B-031;

(18) "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

(19) “Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in KRS 304.17B-003(5);

(20) "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in KRS 304.17B-003(5);

(21) "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

(22) "Medicaid" means coverage in accordance with Title XIX of the Social Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

(23) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

(24) "Pre-existing condition exclusion" is defined in KRS 304.17A-220***(6)*** ~~[(3)]~~;

(25) "Standard health benefit plan" means a health benefit plan that meets the requirements of KRS 304.17A-250;

(26) "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(27) "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employer-controlled or bona fide associations; and

(28) "Utilization management" is defined in KRS 304.17A-500(12).

Section 7. KRS 304.38A-010 is amended to read as follows:

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

(1) "Enrollee" means an individual who is enrolled in a limited health services benefit plan;

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in KRS 304.17C-010 unless exempted by the executive director;

(3) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, chiropractic services, pharmaceutical services, podiatric care services, and such other services as may be determined by the executive director to be limited health services. Limited health service shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the limited health services set forth in this subsection;

(4) "Limited health service contract" means any contract entered into by a limited health service organization with a policyholder to provide limited health services;

(5) "Limited health service organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange limited health service or services to enrollees. A limited health service organization does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited health service organization, health maintenance organization, or a health insurer; and

(6) "Provider" means the same as defined in KRS 304.17A-005***(23)*** ~~[(20)]~~.

Section 8. KRS 304.17C-010 is amended to read as follows:

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

(1) "At the time of enrollment" means the same as defined in KRS 304.17A-005(2);

(2) "Enrollee" means an individual who is enrolled in a limited health service benefit plan;

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005***(23)***~~[(20)]~~;

(4) "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, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

(5) "Limited health service benefit plan" means any policy or certificate that provides services for dental, vision, mental health, substance abuse, chiropractic, pharmaceutical, podiatric, or other such services as may be determined by the executive director to be offered under a limited health service benefit plan. A limited health service benefit plan shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the plan.

Section 9. KRS 304.17A-617 is amended to read as follows:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j). For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

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

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

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

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

2. Serious impairment to bodily functions; or

3. Serious dysfunction of a bodily organ or part;

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

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information;

(e) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for

a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

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

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

3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

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

(3) The office shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(a) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the office shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the office regarding the request for review within ***ten (10) business*** ~~[five (5)]~~ days of receipt of notice to the insurer;

(b) Within ***ten (10) business*** ~~[five (5)]~~ days of receiving the notice of the request for review from the office, the insurer shall provide to the office the following information:

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

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

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

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

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the office is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the office determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the office notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review;

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer;

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the opportunity for external review.

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

An insurer shall not impose a copayment or coinsurance amount charged to the insured for services rendered by a chiropractor licensed under KRS Chapter 312 or an optometrist licensed under KRS Chapter 320 that is greater than the copayment or coinsurance amount charged to the insured for the services of a physician or an osteopath licensed under KRS Chapter 311 for the same or similar diagnosed condition even if different nomenclature is used to describe the condition or complaint.

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

Health benefit plans provided under Kentucky Access shall not impose a copayment or coinsurance amount charged to the insured for services rendered by a chiropractor licensed under KRS Chapter 312 or an optometrist licensed under KRS Chapter 320 that is greater than the copayment or coinsurance amount charged to the insured for the services of a physician or an osteopath licensed under KRS Chapter 311 for the same or similar diagnosed condition even if different nomenclature is used to describe the condition or complaint.

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

An insurer shall not impose a copayment or coinsurance amount charged to the insured for services rendered by a chiropractor licensed under KRS Chapter 312 or an optometrist licensed under KRS Chapter 320 that is greater than the copayment or coinsurance amount charged to the insured for the services of a physician or an osteopath licensed under KRS Chapter 311 for the same or similar diagnosed condition even if different nomenclature is used to describe the condition or complaint.

Became law April 25, 2006, without Governor's signature.