CHAPTER 169

(HB 440)

AN ACT relating to health insurance.

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

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

As used in Sections 1 to 4 of this Act, unless the context requires otherwise:

(1) "Applicant" means a physician licensed under KRS Chapter 311, an advanced registered nurse practitioner licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320 applying for credentialing;

(2) "Enrollee" means a person who is eligible to receive health care services under a managed care plan;

(3) "Managed care plan" means a health benefit plan that integrates the financing and delivery of appropriate health care services to enrollees by arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health care services and financial incentives for enrollees to use the participating providers and procedures provided for in the plan; and

(4) "Nonparticipating provider" means a physician licensed under KRS Chapter 311, an advanced registered nurse practitioner licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320 that has not entered into an agreement with an insurer to provide health care services.

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

(1) An insurer issuing a managed care plan shall notify an applicant of its determination regarding a properly submitted application for credentialing within ninety (90) days of receipt of an application containing all information required by the most recent version of the Council for Affordable Healthcare (CAQH) credentialing form. Nothing in this section shall prevent an insurer from requiring information beyond that contained in the credentialing form to make a determination regarding the application.

(2) The ninety (90) day requirement set forth in subsection (1) of this section shall not apply if the failure to notify is due to or results from, in whole or in part, acts or events beyond the control of the insurer issuing a managed care plan, including but not limited to acts of God, natural disasters, epidemics, strikes or other labor disruptions, war, civil disturbances, riots, or complete or partial disruptions of facilities.

(3) Following credentialing, the applicant and, upon the applicant's signing of a contract with the managed care plan, the insurer shall make payments to the applicant for services rendered during the credentialing process in accordance with procedures for reimbursement for participating providers.

(4) An applicant for which an application for credentialing is denied shall be reimbursed, if the enrollee is enrolled in a plan which provides for out-of-network benefits, by the insurer issuing a managed care plan in accordance with procedures for reimbursement to nonparticipating providers.

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

(1) (a) An insurer issuing a managed care plan shall, upon request of a health care provider, provide or make available the health care provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the health care provider to determine the manner and amount of payments under the contract for the health care provider's services prior to final execution or renewal of the contract. The payment or fee schedule or other information submitted to a health care provider pursuant to this section shall include a description of processes and factors that may be applicable and that may affect actual payment, including copayments, coinsurance, deductibles, risk sharing arrangements, and liability of third parties. Nothing in this paragraph shall prohibit a plan from making any part of the information requested available electronically or via a Web site.

(b) An insurer issuing a managed care plan, upon request of a health care provider, shall provide or make available to the health care provider an explanation of the methodology, such as relative value unit system and conversion factor, percentage of medicare payment system, or percentage of billed charges, used to determine actual payment for procedures frequently performed by the provider that involve combinations of services or payment codes, if the actual payment for the procedures cannot be ascertained from the fee schedule or other information submitted to a health care provider pursuant to this section. As applicable, the methodology disclosure provided for in this paragraph shall include:

1. The name of any relative value system;

2. The version, edition, or publication date of the relative value system; and

3. Any applicable conversion or geographic factor.

Nothing in this paragraph shall prohibit a plan from making any part of the information requested available electronically or via a Web site.

(c) The provisions of this subsection requiring the submission of a fee schedule or other information upon renewal of an existing contract shall not be applicable to renewal of an existing contract when the payment or fee schedule previously provided to the health care provider has not changed.

(2) Any change to payment or fee schedules applicable to providers under contract with an insurer issuing a managed care plan shall be made available to such providers at least ninety (90) days prior to the effective date of the amendment. This subsection shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

(3) A health care provider receiving information pursuant to subsection (1) of this section shall not share this information with an unrelated person without the prior written consent of the insurer issuing a managed care plan. The remedies available to an insurer issuing a managed care plan to enforce the provision of this subsection shall include without limitation injunctive relief. An insurer issuing a managed care plan seeking extraordinary relief to enforce this section shall not be required to establish irreparable harm with regard to the sharing of competitively sensitive information.

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

(1) As used in this section, unless the context requires otherwise:

(a) "Material change" means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense; and

(b) "Participating provider" means a physician licensed under KRS Chapter 311, an advanced registered nurse practitioner licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320 that has entered into an agreement with an insurer to provide health care services.

(2) If an insurer issuing a managed care plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, the insurer shall provide the participating provider with at least ninety (90) days' written notice of the material change. The notice shall include a description of the material change and a statement that the participating provider has the option to withdraw from the agreement prior to the material change becoming effective pursuant to subsection (3) of this section.

(3) A participating provider who opts to withdraw following notice of a material change pursuant to subsection (2) of this section shall send written notice of withdrawal to the insurer no later than forty-five (45) days prior to the effective date of the material change.

(4) If an insurer issuing a managed care plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change.

➔Section 5. KRS 304.17A-254 is amended to read as follows:

An insurer that offers a health benefit plan that is not a managed care plan but provides financial incentives for a covered person to access a network of providers shall:

(1) Notify the covered person, in writing, of the availability of a printed document, in a manner consistent with KRS 304.14-420 to 304.14-450, containing the following information at the time of enrollment and upon request:

(a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider, professional office address, telephone number, and specialty designations of the network provider, if any; and

(b) In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format;

(2) Assure that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be balanced billed by the in-network provider except for deductibles, co-pays, coinsurance amounts, and noncovered benefits;

(3) File with the department a copy of the directory required under subsection (1) of this section;

(4) Have a process for the selection of health care providers who will be on the insurer's list of participating providers, with written policies and procedures for review and approval used by the insurer. The insurer 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;

(5) Not contract with a health care provider to limit the provider's disclosure to a covered person, or to another person on behalf of a covered person, of any information relating to the covered person's medical condition or treatment options;

(6) Not penalize a health care provider, or terminate a health care provider's contract with the insurer, because the provider discusses medically necessary or appropriate care with a covered person or another person on behalf of a covered person. The health care provider may:

(a) Not be prohibited by the insurer from discussing all treatment options with the covered person; and

(b) Disclose to the covered person or to another person on behalf of a covered person other information determined by the health care provider to be in the best interests of the covered person;

(7) Include in any agreements it enters into with providers for the provision of health care services a clause stating that ***the insurer will, upon request of a health care provider, provide or make available to a health care provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the health care provider to determine the manner and amount of payments under the contract for the health care provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of amendment pursuant to Section 3 of this Act***~~[, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request]~~;

(8) Establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board; and

(9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS 304.17A-700 to 304.17A-730.

➔Section 6. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan shall file with the executive director sample copies of any agreements it enters into with providers for the provision of health care services. The executive director shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

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

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

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

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

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

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

(d) A clause stating that ***the insurer issuing a managed care plan will, upon request of a participating provider, provide or make available to a participating provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the provider to determine the manner and amount of payments under the contract for the provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of amendment pursuant to Section 3 of this Act***~~[, upon request, the insurer shall provide the provider with specific fees for requested codes applicable to the compensation that the provider will receive under the contract with the insurer within thirty (30) days of the date of such request]~~; and

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the executive director in accordance with this subsection.

(2) An insurer that offers a health benefit plan that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the executive director. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

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

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

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

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

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

➔Section 7. KRS 304.12-230 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) Failing to comply with the decision of an independent review entity to provide coverage for a covered person as a result of an external review in accordance with KRS 304.17A-621, 304.17A-623, and 304.17A-625***;***

(16) Knowingly and willfully failing to comply with the provisions of KRS 304.17A-714 when collecting claim overpayments from providers; or

(17) Knowingly and willfully failing to comply with the provisions of KRS 304.17A-708 on resolution of payment errors and retroactive denial of claims.

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

(1) All group health benefit plans which provide dependent benefits shall offer the master policyholder the following two (2) options to purchase coverage for an unmarried dependent child:

(a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and

(b) Coverage until age twenty-five (25).

(2) The offer of coverage under paragraph (b) of subsection (1) of this section shall include a disclaimer that selecting either option may have tax implications.

➔Section 9. KRS 304.17-310 is amended to read as follows:

(1) Family expense health insurance is that provided under a policy issued to one (1) of the family members insured, who shall be deemed the policyholder, covering any two (2) or more eligible members of a family, including husband, wife, unmarried dependent children, to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support, and any other person dependent upon the policyholder. Any authorized health insurer may issue the insurance.

(2) An individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state more than 120 days after June 13, 1968, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of mental retardation or physical disability and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer or corporation by the policyholder or subscriber within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(3) Insurers offering family expense health insurance shall offer the applicant the option to purchase coverage for unmarried dependent children until age twenty-five (25).

Signed by Governor April 24, 2008.