CHAPTER 143

(SB 18)

AN ACT relating to medical coverage.

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

➔Section 1. KRS 304.17A-578 is repealed, reenacted as a new section of KRS Chapter 304.17A, and amended to read as follows: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 includes any changes to provider network requirements, or inclusion in any new or modified insurance products***; and

(b) "Participating provider" means a ***provider***~~[physician licensed under KRS Chapter 311, an advanced practice registered nurse 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) ***Each insurer offering a health benefit plan shall establish procedures for changing an existing agreement with a participating provider that shall include the requirements of this section.***

(3) If an insurer offering a health benefit plan makes any 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' notice of the material change. The notice of a material change required under this section shall:

(a) Provide the proposed effective date of the change;

(b) Include a description of the material change;

(c) Include a statement that the participating provider has the option to either accept or reject the proposed material change in accordance with this section;

(d) Provide the name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the material change, if requested by the participating provider;

(e) Provide notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the participating provider. For purposes of this paragraph, "real-time communication" means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and

(f) Provide notice that upon three (3) material changes in a twelve (12) month period, the provider may request a copy of the contract with material changes consolidated into it. Provision of the copy of the contract by the insurer shall be for informational purposes only and shall have no effect on the terms and conditions of the contract.

(4) If a material change relates to the participating provider's inclusion in any new or modified insurance products, or proposes changes to the participating provider's membership networks:

(a) The material change shall only take effect upon the acceptance of the participating provider, evidenced by a written signature; and

(b) The notice of the proposed material change shall be sent by certified mail, return receipt requested.

(5) For any other material change not addressed in subsection (4) of this section:

(a) 1. The material change shall take effect on the date provided in the notice unless the participating provider objects to the change in accordance with this paragraph.

2. A participating provider who objects under this paragraph shall do so in writing and the written protest shall be delivered to the insurer within thirty (30) days of the participating provider's receipt of notice of the proposed material change.

3. Within thirty (30) days following the insurer's receipt of the written objection, the insurer and the participating provider shall confer in an effort to reach an agreement on the proposed change or any counter-proposals offered by the participating provider.

4. If the insurer and participating provider fail to reach an agreement during the thirty (30) day negotiation period described in subparagraph 3. of this paragraph, then thirty (30) days shall be allowed for the parties to unwind their relationship, provide notice to patients and other affected parties, and terminate the contract pursuant to its original terms; and

(b) The notice of proposed material change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer~~[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.]~~

(6)~~[(4)]~~ If an insurer issuing a ***health benefit***~~[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.

(7) Any notice required to be mailed pursuant to this section shall be sent to the participating provider's point of contact, as set forth in the provider agreement. If no point of contact is set forth in the provider agreement, the insurer shall send the requisite notice to the provider's place of business addressed to the provider.

➔Section 2. KRS 205.522 is amended to read as follows:

A managed care organization that provides Medicaid benefits pursuant to this chapter shall comply with the provisions of ***Section 1 of this Act and*** KRS 304.17A-740 to 304.17A-743.

➔Section 3. KRS 304.17C-060 is amended to read as follows:

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

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

1. Nonpayment of moneys due to providers by the insurer;

2. Insolvency of the insurer; 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 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 insurer; and

(c) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide health care services to the subscriber, dependent of the subscriber, or enrollee of a limited health

service benefit plan, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) ***Each insurer shall establish procedures for changing an existing agreement with a participating provider, as defined in Section 1 of this Act, which comply with Section 1 of this Act.***

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

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

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

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

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with the requirements of this subtitle in exercising any delegated administrative functions; and

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

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

➔Section 4. KRS 304.17A-258 is amended to read as follows:

(1) For purposes of this section:

(a) "Therapeutic food, formulas, and supplements" means products intended for the dietary treatment of inborn errors of metabolism or genetic conditions***, including but not limited to mitochondrial disease,*** under the direction of a physician***, and includes the use of vitamin and nutritional supplements such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2, vitamin K1, and L-carnitine***; and

(b) "Low-protein modified food" means a product formulated to have less than one (1) gram of protein per serving and intended for the dietary treatment of inborn errors of metabolism or genetic conditions under the direction of a physician.

(2) A health benefit plan that provides prescription drug coverage shall include in that coverage therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions***, including those that are compounded,*** if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions***, including but not limited to mitochondrial disease,*** under the direction of a physician. Coverage under this subsection may be subject, for each plan year, to a cap of twenty-five thousand dollars ($25,000) for therapeutic food, formulas, and supplements and a separate cap for each plan year of four thousand dollars ($4,000) on low-protein modified foods. Each cap shall be subject to annual inflation adjustments based on the consumer price index. ***Coverage under this section shall not be denied because two (2) or more supplements are compounded.***

(3) The requirements of this section shall apply to all health benefit plans issued or renewed on and after ***the effective date of this Act***~~[July 15, 2008]~~.

(4) Nothing in this section or KRS 205.560, 213.141, or 214.155 shall be construed to require a health benefit plan to provide coverage for therapeutic foods, formulas, supplements, or low-protein modified food for the treatment of lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition or disease that is not an inborn error of metabolism or genetic condition.

➔Section 5. This Act takes effect January 1, 2017.

Became law without Governor's signature April 28, 2016.