CHAPTER 25

(SB 79)

AN ACT relating to health care providers.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 311 IS CREATED TO READ AS FOLLOWS:

As used in this section and Section 2 of this Act:

(1) "Direct primary care membership agreement" means a written contractual agreement between a primary care provider and an individual patient or his or her legal guardian that:

(a) Is for an agreed-upon fee over an agreed-upon period of time;

(b) Describes the primary care services to be provided in exchange for the agreed-upon fee;

(c) States that the primary care provider shall not bill a health benefit plan or the Medicaid program on a fee-for-service basis for the primary care services provided under the agreement;

(d) Specifies automatic agreement renewal periods;

(e) Specifies any additional fees that may be charged for primary care services that are not included in the agreement;

(f) States that the patient is not required to pay more than twelve (12) months of the agreed-upon fee in advance;

(g) States that the agreed-upon fee and any additional fees may be paid by a third party;

(h) Allows either party to terminate the agreement in writing, without penalty or payment of a termination fee, after notice;

(i) Provides that, upon termination of the agreement by the patient or his or her legal guardian, all unearned fees are to be returned to the patient, his or her legal guardian, or any third-party payor; and

(j) Contains a conspicuous and prominent statement that the agreement does not constitute a health benefit plan and does not meet any individual health benefit plan mandate that may be required by federal law;

(2) "Health benefit plan" has the same meaning as in KRS 304.17A-005;

(3) "Primary care provider" means a physician as defined by KRS 311.550 or a physician's medical practice that enters into a direct primary care membership agreement;

(4) "Primary care service" means the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency and training of the primary care provider; and

(5) "Third party" means a legal guardian, the individual patient's employer, a spouse's employer, a family member of the patient, or a state-sponsored direct primary care payment program. Third party does not include a network designed to merely accept payment from a patient and then direct the patient to one (1) of several independently owned clinics for the delivery of care.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 311 IS CREATED TO READ AS FOLLOWS:

(1) Receiving primary care services under a direct primary care membership agreement shall not require a patient or his or her legal guardian to forfeit coverage under a health benefit plan.

(2) The offer or provision of primary care services under a direct primary care membership agreement shall not be deemed an offer or provision of coverage under a health benefit plan and shall not be regulated under KRS Chapter 304.

(3) A primary care provider shall not be required to obtain a license to market, sell, or offer to sell a direct primary care membership agreement.

(4) All services provided pursuant to this section shall be consistent with KRS Chapter 311 for physicians.

➔Section 3. KRS 304.1-120 is amended to read as follows:

No provision of this code shall apply to:

(1) Fraternal benefit societies (as identified in Subtitle 29), except as stated in Subtitle 29.

(2) Nonprofit hospital, medical-surgical, dental, and health service corporations (as identified in Subtitle 32) except as stated in Subtitle 32.

(3) Burial associations (as identified in KRS Chapter 303), except as stated in Subtitle 31.

(4) Assessment or cooperative insurers (as identified in KRS Chapter 299), except as stated in KRS Chapter 299.

(5) Insurance premium finance companies (as identified in Subtitle 30), except as stated in Subtitle 30.

(6) Qualified organizations which issue charitable gift annuities within the Commonwealth of Kentucky. For the purposes of this subsection:

(a) A "qualified organization" means one which is:

1. Exempt from taxation under Section 501(c)(3) of the Internal Revenue Code as a charitable organization, if it files a copy of federal form 990 with the Division of Consumer Protection in the Office of the Attorney General; or

2. Exempt from taxation under Section 501(c)(3) of the Internal Revenue Code as a religious organization; or

3. Exempt as a publicly owned or nonprofit, privately endowed educational institution approved or licensed by the State Board of Education, the Southern Association of Colleges and Schools, or an equivalent public authority of the jurisdiction where the institution is located; and

(b) A "charitable gift annuity" means a giving plan or method by which a gift of cash or other property is made to a qualified organization in exchange for its agreement to pay an annuity.

(7) A religious organization, as identified in this subsection, or its participants, that:

(a) Is a nonprofit religious organization;

(b) Is limited to participants who are members of the same denomination or religion;

(c) Matches its participants who have financial, physical, or medical needs with participants who choose to assist with those needs;

(d) 1. Includes the following notice for delivery to all participants, printed in not less than ten (10) point, bold-faced type on or accompanying all applications, guideline materials, or any similar documents:

"NOTICE: UNDER KENTUCKY LAW, THE RELIGIOUS ORGANIZATION FACILITATING THE SHARING OF MEDICAL EXPENSES IS NOT AN INSURANCE COMPANY, AND ITS GUIDELINES, PLAN OF OPERATION, OR ANY OTHER DOCUMENT OF THE RELIGIOUS ORGANIZATION DO NOT CONSTITUTE OR CREATE AN INSURANCE POLICY. PARTICIPATION IN THE RELIGIOUS ORGANIZATION OR A SUBSCRIPTION TO ANY OF ITS DOCUMENTS SHALL NOT BE CONSIDERED INSURANCE. ANY ASSISTANCE YOU RECEIVE WITH YOUR MEDICAL BILLS WILL BE TOTALLY VOLUNTARY. NEITHER THE ORGANIZATION OR ANY PARTICIPANT SHALL BE COMPELLED BY LAW TO CONTRIBUTE TOWARD YOUR MEDICAL BILLS. WHETHER OR NOT YOU RECEIVE ANY PAYMENTS FOR MEDICAL EXPENSES, AND WHETHER OR NOT THIS ORGANIZATION CONTINUES TO OPERATE, YOU SHALL BE PERSONALLY RESPONSIBLE FOR THE PAYMENT OF YOUR MEDICAL BILLS."

2. A participant shall acknowledge receipt of the "Notice" by signing below the "Notice" on the application;

(e) Suggests amounts to give that are voluntary among the participants, with no assumption of risk or promise to pay either among the participants or between the participants and the organization.

(8) A public or private ambulance service licensed and regulated by the Cabinet for Health and Family Services to the extent that it solicits membership subscriptions, accepts membership applications, charges membership fees, and furnishes prepaid or discounted ambulance services to subscription members and designated members of their households.

(9) A direct primary care agreement established under Sections 1, 2, 5, and 6 of this Act.

➔Section 4. 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;

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 the 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) 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) "Employer-organized association" means any of the following:

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

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

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

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in subsection (30) of this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in subsection (5) of this section shall be treated as a large group under this subtitle;

(13) "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) "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;

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

(20) "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) "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) "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***, or direct primary care agreements established under Sections 1, 2, 5, and 6 of this Act***;

(23) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS Chapter 315, or home medical equipment and services provider as defined pursuant to KRS 309.402, 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 practice registered nurses licensed under KRS Chapter 314; and

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

(24) (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 commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the

commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

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

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

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

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

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

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

(30) "Large group" means:

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

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

(c) An employer-organized association that is a bona fide association as defined in subsection (5) of this section;

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

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

(38) "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) "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) "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) "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) "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) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(44) "Telehealth" has the meaning provided in KRS 311.550.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 314 IS CREATED TO READ AS FOLLOWS:

As used in this section and Section 6 of this Act:

(1) "Direct primary care membership agreement" means a written contractual agreement between a primary care provider and an individual patient or his or her legal guardian that:

(a) Is for an agreed-upon fee over an agreed-upon period of time;

(b) Describes the primary care services to be provided in exchange for the agreed-upon fee;

(c) States that the primary care provider shall not bill a health benefit plan or the Medicaid program on a fee-for-service basis for the primary care services provided under the agreement;

(d) Specifies automatic agreement renewal periods;

(e) Specifies any additional fees that may be charged for primary care services that are not included in the agreement;

(f) States that the patient is not required to pay more than twelve (12) months of the agreed-upon fee in advance;

(g) States that the agreed-upon fee and any additional fees may be paid by a third party;

(h) Allows either party to terminate the agreement in writing, without penalty or payment of a termination fee, after notice;

(i) Provides that, upon termination of the agreement by the patient or his or her legal guardian, all unearned fees are to be returned to the patient, his or her legal guardian, or any third-party payor; and

(j) Contains a conspicuous and prominent statement that the agreement does not constitute a health benefit plan and does not meet any individual health benefit plan mandate that may be required by federal law;

(2) "Health benefit plan" has the same meaning as in KRS 304.17A-005;

(3) "Primary care provider" means an advanced practice registered nurse as defined by KRS 314.011 or an advanced practice registered nurse's practice that enters into a direct primary care membership agreement;

(4) "Primary care service" means the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency and training of the primary care provider; and

(5) "Third party" means a legal guardian, the individual patient's employer, a spouse's employer, a family member of the patient, or a state-sponsored direct primary care payment program. Third party does not include a network designed to merely accept payment from a patient and then direct the patient to one (1) of several independently owned clinics for the delivery of care.

➔SECTION 6. A NEW SECTION OF KRS CHAPTER 314 IS CREATED TO READ AS FOLLOWS:

(1) Receiving primary care services under a direct primary care membership agreement shall not require a patient or his or her legal guardian to forfeit coverage under a health benefit plan.

(2) The offer or provision of primary care services under a direct primary care membership agreement shall not be deemed an offer or provision of coverage under a health benefit plan and shall not be regulated under KRS Chapter 304.

(3) A primary care provider shall not be required to obtain a license to market, sell, or offer to sell a direct primary care membership agreement.

(4) All services provided pursuant to this section shall be consistent with KRS Chapter 314 for advanced practice registered nurses.

Signed by Governor March 17, 2017.