CHAPTER 146

(HB 662)

AN ACT relating to personally identifiable information.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 61 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Covered person" means a judicial officer or an immediate family member of a judicial officer;

(b) "Disclose" means to post, display, publish, or otherwise make publicly available;

(c) "Immediate family member" means:

1. A spouse, child, parent, or person under the familial custody or care of a judicial officer; or

2. Any other familial relative who resides in the same household as the judicial officer;

(d) "Judicial officer" means any active or senior judge and includes a:

1. Justice of the United States or a judge of the United States as those terms are defined in 28 U.S.C. sec. 451;

2. Bankruptcy judge appointed under 28 U.S.C. sec. 152 or recalled pursuant to 28 U.S.C. sec. 375;

3. United States magistrate judge appointed under 28 U.S.C. sec. 631 or recalled pursuant to 28 U.S.C. sec. 375;

4. Judge confirmed by the United States Senate and empowered by statute in any commonwealth, territory, or possession to perform the duties of a federal judge;

5. Judge of the United States Court of Federal Claims appointed under 28 U.S.C. sec. 171; and

6. Justice, judge, trial commissioner, or domestic relations commissioner of the Kentucky Court of Justice;

(e) "Personally identifiable information" means data that can identify a covered person and includes:

1. Date of birth;

2. Biometric, health, or medical data, or insurance information;

3. Residence addresses of the covered person;

4. Home or cellular telephone numbers;

5. Personal email addresses;

6. Identities of the children of a judicial officer and names and locations of schools and daycare facilities they attend;

7. Social Security number; and

8. The name of an immediate family member's employer; and

(f) "Written request" means a notice signed by a covered person requesting a government agency refrain from posting or displaying publicly available content that includes the personally identifiable information of the covered person.

(2) (a) A government agency shall not disclose the personally identifiable information of any covered person if the covered person has made a written request to the government agency that this personally identifiable information not be disclosed.

(b) Upon receipt of the written request, personally identifiable information shall be removed from publicly available content within seventy-two (72) hours.

(c) A request under this subsection may be made on behalf of a minor who is a covered person by a parent or guardian of the minor.

(3) After the government agency has removed the personally identifiable information from publicly available content, the government agency shall not publicly post or otherwise release the information unless the covered person voluntarily publishes the information on the internet after the effective date of this Act.

(4) A covered person may bring a civil action seeking injunctive or declaratory relief to enforce this section in any court of competent jurisdiction.

➔Section 2. KRS 304.17A-540 is amended to read as follows:

(1) Any insurer that limits coverage for any treatment, procedure, a drug, or device shall define the limitations and fully disclose those limits in the health insurance policy or certificate coverage.

(2) (a) Any insurer that denies coverage for a treatment, procedure, a drug that requires prior approval, or device for an enrollee shall provide the enrollee with a denial letter that shall include:

1. The ~~[name, license number,]~~state of licensure~~[,]~~ and title of the person making the decision;

2. A statement setting forth the specific medical and scientific reasons for denying coverage of a service, if the coverage is denied for reasons of medical necessity; and

3. Instructions for initiating or complying with the plan's grievance or appeal procedure stating at a minimum whether the appeal must be in writing, any time limitations or schedules for filing appeals and the name and phone number of a contact person who can provide additional information.

(b) The denial letter shall be provided within:

1. Two (2) regular working days of the submitted request where preauthorization for a treatment, procedure, drug, or device is involved;

2. Twenty-four (24) hours of the submitted request where hospital preadmission review is sought;

3. Twenty (20) working days of the receipt of requested medical information where the plan has initiated a retrospective review; and

4. Twenty (20) working days of the initiation of the review process in all other instances.

➔Section 3. KRS 304.17A-545 is amended to read as follows:

(1) A managed care plan shall appoint a medical director who:

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

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

(c) Has not had his or her license revoked or suspended~~[,]~~ under KRS 311.530 to 311.620; ***and***

(d) ~~[Shall sign any denial letter required under KRS 304.17A-540; and~~

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

(2) The medical director shall ensure that:

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

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

(c) In the case of a managed care plan, a procedure is implemented whereby***:***

1. Participating physicians have an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer***;*** and~~[whereby]~~

2. Other participating providers have an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice;

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

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

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

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

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

(c) Performance and clinical outcomes-based criteria;

(d) A procedure for remedial action to correct quality problems, including written procedures for taking appropriate corrective action;

(e) A plan for data gathering and assessment; and

(f) A peer review process.

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

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

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

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

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

(5) The commissioner shall promulgate administrative regulations to establish a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers in accordance with subsection (4) of this section. In developing a uniform application and guidelines, the department shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.

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

➔Section 4. KRS 304.17A-617 is amended to read as follows:

(1) (a) 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).

(b) 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).

(c) 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.

(d) 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.

(3) 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) Except as provided in KRS 304.17A-163:

1. 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; and

2. 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:

a. 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;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of a bodily organ or part;

(b) 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***~~[board-eligible]~~ or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(c) 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; and

(d) 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***, except that an internal appeal determination letter provided to a provider acting on behalf of the covered person shall also include the medical license number 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 department if a coverage denial is upheld by the insurer on internal appeal.

(4) (a) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers.

(b) 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.

(c) On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within ten (10) business days of receipt of notice to the insurer.

(d) Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department 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.

(e) In addition to the information described in paragraph (d) of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review.

(f) 1. On the receipt of the information described in paragraphs (d) and (e) of this subsection, unless the department 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.

2. If the department 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.

3. If the department 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.

(g) 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 (f) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(h) 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 5. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that, for any contract entered into on or after January 1, 2020, for the provision of utilization review services, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a ***toll-free***~~[toll-free]~~ telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, or as otherwise provided in this subtitle, provide a utilization review decision in accordance with the timeframes in paragraph (i) of this subsection and 29 C.F.R. Part 2560, including written notice of the decision;

(i) 1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and

2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information to make the utilization review decision.

For purposes of this paragraph, "necessary information" is limited to:

a. The results of any face-to-face clinical evaluation;

b. Any second opinion that may be required; and

c. Any other information determined by the department to be necessary to making a utilization review determination;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. The written notice may be provided in an electronic format, including ***email***~~[e-mail]~~ or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically. An insurer or agent that denies a step therapy exception, as defined in KRS 304.17A-163, or denies coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

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

2. The ~~[medical license number and the]~~title of the reviewer making the decision***, except that a written notice provided to a provider shall also include the medical license number of the reviewer 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 or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's or private review agent's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be a prior authorization for the health care services or benefits subject to the review. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

Signed by Governor April 1, 2025.