

AN ACT relating to emergency health services.

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

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

**(1) The board shall annually:**

**(a) Obtain the charges billed for services provided in this state from all air ambulance providers licensed and operating in this state, and the information provided to the board shall be deemed proprietary information and shall not be subject to the Open Records Act, KRS 61.870 to 61.884;**

**(b) Determine the average cost of all air ambulance services in this state using information obtained under paragraph (a) of this subsection. The average cost shall be subject to the provisions of the Open Records Act, KRS 61.870 to 61.884; and**

**(c) Submit the average cost of all air ambulance services in this state to the commissioner of the Department of Insurance.**

**(2) The board may promulgate administrative regulations to establish a form to be completed by all air ambulance service providers necessary to determine the average cost of all air ambulance services operating in this state.**

➔Section 2. KRS 311A.190 is amended to read as follows:

(1) Each licensed ambulance provider and medical first response provider as defined in this chapter shall collect and provide to the board run data and information required by the board by this chapter and administrative regulation.

(2) The board shall develop a run report form for the use of each class of ambulance provider and medical first response provider containing the data required in subsection (1) of this section. An ambulance provider or medical first response provider may utilize any run form it chooses in lieu of or in addition to the board developed run report form. However, the data captured on the run report form shall

include at least that required by the administrative regulations promulgated pursuant to subsection (1) of this section.

- (3) An ambulance provider or medical first response provider shall report the required run report data and information by completing an annual report as established by the board or by transmitting the required data and information to the board in an electronic format. If the board requires the use of a specific electronic format, it shall provide a copy of the file layout requirements, in either written or electronic format, to the licensed ambulance provider or medical first response provider at no charge.
- (4) The board may publish a comprehensive annual report reflecting the data collected, injury and illness data, treatment utilized, and other information deemed important by the board. The annual report shall not include patient identifying information or any other information identifying a natural person. A copy of the comprehensive annual report, if issued, shall be forwarded to the Governor and the General Assembly.
- (5) Ambulance provider and medical first response provider run report forms and the information transmitted electronically to the board shall be confidential. No person shall make an unauthorized release of information on an ambulance run report form or medical first response run report form. Only the patient or the patient's parent or legal guardian if the patient is a minor, or the patient's legal guardian or person with proper power of attorney if the patient is under legal disability as being incompetent or mentally ill, or a court of competent jurisdiction may authorize the release of information on a patient's run report form or the inspection or copying of the run report form. Any authorization for the release of information or for inspection or copying of a run report form shall be in writing.
- (6) If a medical first response provider or ambulance provider does not use a paper form but collects patient data through electronic means, it shall have the means of

providing a written run report that includes all required data elements to the medical care facility. A copy of the medical first response form or a summary of the run data and patient information shall be made available to the ambulance service that transports the patient. A copy of the ambulance run report form shall be made available to any medical care facility to which a patient is transported and shall be included in the patient's medical record by that facility. If a patient is not transported to a medical facility, the copy of the run report form that is to be given to the transporting ambulance provider or medical care facility shall be given to the patient or to the patient's parent or legal guardian. If the ambulance provider, medical facility, patient, or patient's legal guardian refuses delivery of their run report form or is unavailable to receive the form, that copy of the form shall be returned to the medical first response provider or ambulance provider and destroyed.

- (7) All ambulance services shall be required to keep adequate reports and records to be maintained at the ambulance base headquarters and to be available for periodic review as deemed necessary by the board. Required records and reports are as follows:
  - (a) Employee records, including a resume of each employee's training and experience and evidence of current certification; and
  - (b) Health records of all drivers and attendants including records of all illnesses or accidents occurring while on duty.
- (8) Data and records generated and kept by the board or its contractors regarding the evaluation of emergency medical care and trauma care in the Commonwealth, including the identities of patients, emergency medical services personnel, ambulance providers, medical first-response providers, and emergency medical facilities, shall be confidential, shall not be subject to disclosure under KRS 61.805 to 61.850 or KRS 61.870 to 61.884, shall not be admissible in court for any purpose, and shall not be subject to discovery. However, nothing in this section

shall limit the discoverability or admissibility of patient medical records regularly and ordinarily kept in the course of a patient's treatment that otherwise would be admissible or discoverable.

**(9) Each air ambulance provider licensed and operating in this state shall provide the board with information regarding charges for services provided in the Commonwealth in accordance with Section 1 of this Act.**

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

**(1) Each insurer offering health benefit plans issued or renewed in Kentucky on or after the effective date of this Act that provide coverage for emergency air ambulance transport shall annually submit to the department the maximum coverage for emergency air ambulance services under every health benefit plan offered by that insurer. The information provided to the department under this section shall be deemed proprietary information and kept confidential, and shall not be subject to the Open Records Act, KRS 61.870 to 61.884.**

**(2) Each health benefit plan issued in Kentucky shall conspicuously include one (1) of the following notices on the contract concerning emergency air ambulance transport in all capital letters in no less than twelve (12) point type:**

**(a) If the health benefit plan does not include emergency air ambulance services coverage, the following language shall be included in the notice:**

**"THIS PLAN DOES NOT PROVIDE COVERAGE FOR ANY EMERGENCY AIR AMBULANCE SERVICES.**

**THE AVERAGE COVERAGE AMOUNT FOR EMERGENCY AIR AMBULANCE SERVICES IN KENTUCKY IN THE LAST THREE (3) YEARS IS (insert dollar amount) AS DETERMINED BY THE DEPARTMENT OF INSURANCE.**

**THE AVERAGE COST FOR EMERGENCY AIR AMBULANCE**

SERVICES IN THIS STATE IN THE LAST THREE (3) YEARS IS (insert dollar amount), AS DETERMINED BY THE KENTUCKY BOARD OF EMERGENCY MEDICAL SERVICES. THE COST OF EMERGENCY AIR AMBULANCE SERVICES MAY BE MORE OR LESS THAN THE AVERAGE IN THIS STATE, DEPENDING ON YOUR LOCATION AT THE TIME OF SERVICE, THE MEDICAL SERVICES PROVIDED WHILE IN FLIGHT, AND THE DISTANCE TRAVELED BY THE AIR AMBULANCE SERVICE PROVIDER.

A LICENSED PUBLIC OR PRIVATE AIR AMBULANCE SERVICE MAY SELL MEMBERSHIPS TO COVER THE COST OR TO SUPPLEMENT HEALTH INSURANCE TO COVER THE COST OF AIR AMBULANCE SERVICE."; or

(b) If the health benefit plan covers all or a portion of the cost of emergency air ambulance services, the following language shall be included in the notice:

"THE MAXIMUM AMOUNT OF COVERAGE UNDER THIS PLAN FOR EMERGENCY AIR AMBULANCE SERVICES IS (insert dollar amount), SUBJECT TO ANY DEDUCTIBLE, COPAYMENT, OR COINSURANCE. THE AVERAGE COVERAGE AMOUNT FOR EMERGENCY AIR AMBULANCE SERVICES IN KENTUCKY IN THE LAST THREE (3) YEARS IS (insert dollar amount) AS DETERMINED BY THE DEPARTMENT OF INSURANCE.

THE AVERAGE COST OF EMERGENCY AIR AMBULANCE SERVICES IN THIS STATE IN THE LAST THREE (3) YEARS IS (insert dollar amount) AS DETERMINED BY THE KENTUCKY BOARD OF EMERGENCY MEDICAL SERVICES. THE COST OF EMERGENCY AIR AMBULANCE SERVICES MAY BE MORE OR LESS THAN THE AVERAGE IN THIS STATE, DEPENDING ON YOUR LOCATION AT

THE TIME THE SERVICE IS NEEDED, THE MEDICAL SERVICES PROVIDED WHILE IN FLIGHT, AND THE DISTANCE TRAVELED BY THE AIR AMBULANCE SERVICE PROVIDER.

YOU MAY BE RESPONSIBLE FOR PAYING THE AIR AMBULANCE SERVICE PROVIDER FOR THE BALANCE OF THE AIR AMBULANCE SERVICE'S BILL.

A LICENSED PUBLIC OR PRIVATE AIR AMBULANCE SERVICE MAY SELL MEMBERSHIPS TO COVER THE COST OR TO SUPPLEMENT HEALTH INSURANCE TO COVER THE COST OF AIR AMBULANCE SERVICE."

(3) The commissioner shall:

- (a) Review all health benefit plans offered in the state to determine if the requirements of this section have been met by the insurer;
- (b) Determine the average coverage of EMERGENCY air ambulance services provided by health benefit plans offered in Kentucky using information obtained under subsection (1) of this section. Notwithstanding subsection (1) of this section, the average coverage amount shall be subject to the provisions of the Open Records Act, KRS 61.870 to 61.884; and
- (c) Every three (3) years, provide to all insurers offering health benefit plans in this state:
  1. The average cost of all EMERGENCY air ambulance services in this state; and
  2. The average coverage amount for EMERGENCY air ambulance services offered by health benefit plans issued in this state.

➔Section 4. KRS 304.17A-580 is amended to read as follows:

- (1) An insurer offering health benefit plans shall educate its insureds about the availability, location, and appropriate use of emergency and other medical services,

cost-sharing provisions for emergency services, and the availability of care outside an emergency department.

- (2) An insurer offering health benefit plans shall cover emergency medical conditions and shall pay for emergency department screening, ~~and~~ stabilization services, **and transportation** both in-network and out-of-network without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based on the patient's presenting symptoms and condition. An insurer shall be prohibited from denying the emergency room services and altering the level of coverage or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition as defined in KRS 304.17A-500.
- (3) **For emergency air ambulance services required to be paid under subsection (2) of this section, an insurer shall pay the usual and customary rate of the air ambulance service provider.**
- (4)** Emergency department personnel shall contact a patient's primary care provider or insurer, as appropriate, as quickly as possible to discuss follow-up and poststabilization care and promote continuity of care.
- ~~(5)~~~~(4)~~ Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited-benefit health insurance policies.

➔Section 5. KRS 304.17A-702 is amended to read as follows:

- (1) Except for claims involving organ transplants, each insurer shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within thirty (30) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurer. Clean claims involving organ transplants shall be paid, denied, or contested within sixty (60) calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the

insurer.

- (2) Within the applicable claims payment time frame, an insurer shall:
- (a) Pay the total amount of the claim in accordance with any contract between the insurer and the provider;
  - (b) Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, of the reasons the remaining portion of the claim will not be paid;~~[-or]~~
  - (c) Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid; or
  - (d) For claims involving air ambulance services, whether provided by an in-network or out-of-network air ambulance service provider, pay the total amount of the claim payable under the health benefit plan's policy directly to the air ambulance service. If any part of the claim is in dispute, the insurer shall follow the procedures required in paragraphs (b) and (c) of this subsection.**