AN ACT relating to health care transparency.

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

➔Section 1. 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) "Covered service" means a health care service available to an insured under the terms of the insured's health benefit plan;

(9) ~~[(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;

(10)~~[(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;

(11) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition in which the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

(b) With respect to a pregnant woman who is having contractions:

1. A situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or

2. A situation in which transfer may pose a threat to the health or safety

of the woman or the unborn child;

(12) ~~[(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;

(13) ~~[(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;

(14) ~~[(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" ***in***~~[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;

(15)~~[(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;

(16)~~[(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;

(17) ~~[(15)]~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(18) ~~[(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;

(19) ~~[(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;

(20) ~~[(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;

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

(22) ~~[(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;

(23) ~~[(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;

(24) ~~[(22)]~~ ***(a)*** "Health benefit plan" means any**:**

1. Hospital or medical expense policy or certificate;

2. Nonprofit hospital, medical-surgical, and health service corporation contract or certificate;

3. Provider sponsored integrated health delivery network;

4. ~~[A]~~Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;

5. Health maintenance organization contract; or

6. ~~[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]~~

(b) The term does not include**:**

1. Policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement~~[policy]~~, long-term care, Medicare supplement, specified disease, ***or*** vision care**;**~~[,]~~

2. Coverage issued as a supplement to liability insurance**;**~~[,]~~

3. Insurance arising out of a workers' compensation or similar law**;**~~[,]~~

4. Automobile medical-payment insurance**;**~~[,]~~

5. 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**;**~~[,]~~

6. Short-term coverage**;**~~[,]~~

7. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure**;**~~[,]~~

8. 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]~~

9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code**;**~~[, or]~~

10. Limited health service benefit plans**;**~~[,]~~ or

11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199;

(25)~~[(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;

(26) "Health care service" means a health care procedure, treatment, or service rendered by a provider within the scope of practice for which the provider is licensed in Kentucky. "Health care service" includes the provision of pharmaceutical products or services and durable medical equipment;

(27) ~~[(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;

(28) ~~[(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;

(29) ~~[(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;

(30) "Insured" or "covered person" means an individual entitled to receive benefits or services under the terms of a health benefit plan;

(31) ~~[(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;

(32) ~~[(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;

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

(34) ~~[(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;

(35) ~~[(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;

(36) ~~[(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;

(37) ~~[(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;

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

(39) ~~[(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;

(40) ~~[(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;

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

(42) ~~[(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;

(43) ~~[(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;

(44) ~~[(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;

(45) ~~[(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;

(46) ~~[(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;

(47) ~~[(43)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

(48) ~~[(44)]~~ "Telehealth" has the meaning provided in KRS 311.550.

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

(1) As used in this section:

(a) "Allowed amount" means the contractually agreed-upon amount paid by an insurer to a participating provider for a health care service provided to a covered person;

(b) "Average allowed amount" means:

1. The mean, median, or mode of all allowed amounts paid, within a reasonable time frame not to exceed one (1) year, for a health care service to:

a. Participating providers in the provider network of a covered person's health benefit plan; or

b. Providers that have entered into a contract with a covered person's insurer to provide health care services under the terms of any health benefit plan offered by that insurer in Kentucky; or

2. Any amount determined by an insurer using an alternative calculation

method if the method is approved by the commissioner;

(c) 1. "Comparable health care service" means any nonemergency health care service that is:

a. A covered service;

b. Provided by a participating provider that receives or agrees to receive an allowed amount that is less than the average allowed amount paid for the health care service; and

c. Not excluded by the commissioner pursuant to subparagraph 2. of this paragraph.

2. The commissioner may exclude a health care service from the definition of "comparable health care service" if an insurer can demonstrate that the variation in allowed amounts paid for the health care service during a reasonable time frame determined by the commissioner is less than fifty dollars ($50);

(d) "Nonemergency health care service" means a health care service that does not involve the treatment of an emergency medical condition;

(e) "Nonparticipating provider" means a provider that has not entered into an agreement with a covered person's insurer to provide health care services to the covered person; and

(f) "Participating provider" means a provider that has entered into an agreement with a covered person's insurer to provide health care services to the covered person.

(2) (a) For all health benefit plans issued or renewed on or after the effective date of this Act, insurers shall develop and implement a program that provides incentives for covered persons who elect to receive a comparable health care service. The incentive program shall be a component of all health benefit plans offered in Kentucky.

(b) Incentives shall:

1. Be calculated:

a. As a percentage or flat dollar amount of the difference between the allowed amount and the average allowed amount; or

b. By another reasonable method approved by the commissioner;

2. Be at least fifty percent (50%) of the health benefit plan's saved costs for each comparable health care service received by a covered person, except a plan shall not be required to provide an incentive when the saved cost is twenty-five dollars ($25) or less;

3. Be made as a:

a. Cash payment to the covered person; or

b. Credit towards the covered person's annual deductible and out-of-pocket limit; and

4. Not be an administrative expense for rate development or rate filing purposes.

(c) A health benefit plan may allow covered persons to elect the method in which the person receives an incentive.

(d) A health benefit plan shall, at a minimum, provide notice of the following to covered persons:

1. The availability of the incentive program and a description of the incentives available;

2. How covered persons can earn incentives; and

3. That a covered person may request and obtain information from the interactive mechanism established pursuant to subsection (3) of this section.

(e) The notices required by paragraph (d) of this subsection shall be provided:

1. On each insurer's Web site; and

2. In the disclosures required by Section 4 of this Act.

(f) 1. Unless otherwise permitted pursuant to subparagraph 2. of this paragraph, an insurer shall file with the department, for each health benefit plan, the following information for the most recent calendar year:

a. The total number and amount of incentive payments made to covered persons pursuant to this section;

b. The total number and percentage of covered persons that received a comparable health care service; and

c. By category of service:

i. The total number of comparable health care services used for which incentive payments were made;

ii. The average amount of incentive payments made; and

iii. The total savings achieved.

2. The commissioner may set reasonable limits on the reporting required by this paragraph to focus on the more popular comparable heath care services.

(g) By June 1, 2020, and annually by June 1 of each year thereafter, the department shall submit an aggregate report of the data received pursuant to paragraph (f) of this subsection to the Interim Joint Committee on Banking and Insurance.

(3) (a) For all health benefit plans issued or renewed on or after the effective date of this Act, insurers shall establish an interactive mechanism on a publicly accessible Web site that enables covered persons to request and obtain:

1. For each participating provider:

a. The allowed amount paid for each comparable health care service provided by and, to the extent available, quality data for

that participating provider; and

b. The allowed amount paid for any nonemergency health care service that is a covered service provided by that participating provider;

2. The average allowed amount for any nonemergency health care service that is a covered service; and

3. A good-faith estimate of the out-of-pocket costs applicable to the covered person for a nonemergency health care service that is a covered service, including but not limited to any copayment, deductible, or coinsurance.

(b) The good-faith estimate required by paragraph (a)3. of this subsection:

1. Shall be based on information available to the insurer at the time the request is made;

2. May be provided by a third-party vendor contracted to provide the estimate;

3. Shall also be available to the covered person through a toll-free telephone number;

4. Shall not prohibit the health benefit plan from imposing cost-sharing requirements disclosed in the plan for unforeseen health care services that arise out of a nonemergency health care service or for a health care service that was not included in the original estimate; and

5. Shall include a notification to the covered person that the costs disclosed are an estimate and that the actual amount the covered person is responsible for paying may vary from the original estimate due to unforeseen services that arise out of a nonemergency health care service.

(4) (a) All health benefit plans issued or renewed on or after the effective date of

this Act shall provide coverage as set forth in paragraph (b) of this subsection for nonemergency health care services provided by a nonparticipating provider to a covered person if:

1. The health care service is a service that is covered by the health benefit plan, but is:

a. Not eligible for payment under the plan unless the service is provided by a participating provider; or

b. Eligible for payment under the plan at terms that are more favorable to the covered person if the service is provided by a participating provider; and

2. The price of the health care service is the same or less than the average allowed amount for that health care service.

(b) Upon request by the covered person, the insurer shall pay the nonparticipating provider's price and apply the payment made to any in-network deductible and out-of-pocket maximum that are required by the person's health benefit plan.

(c) For each health benefit plan, insurers shall provide a downloadable or interactive online form to the covered person for any proof of payment that may be required to demonstrate compliance with this subsection.

➔Section 3. 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 ***as defined in KRS 304.17A-500,*** but ***that*** 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 ***shall*** ~~[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) A copy of the directory required ***by*** ~~[under]~~ subsection (1) of this section; ***and***

(b) A description of the incentive program required by subsection (2) of Section 2 of this Act. The filing shall be made prior to offering the program to any covered person and in a manner and form prescribed by the commissioner. The filing, and any supporting documentation, shall be confidential until it is approved or disapproved by the commissioner.

(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 ***shall*** ~~[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 ***the following clauses:***~~[a clause stating]~~

(a) ~~[That]~~The insurer ***shall***~~[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 the amendment pursuant to KRS 304.17A-577;

(b) 1. a. The health care provider shall provide a covered person who is a patient or a prospective patient information that is available to the provider regarding any proposed nonemergency health care service offered to the covered person. The information shall be sufficient for the person to receive a good-faith estimate pursuant to subsection (3) of Section 2 of this Act.

b. Except as otherwise provided in subparagraph 3. of this paragraph, the information required by subdivision a. of this

subparagraph shall be provided within two (2) working days of the date the proposed nonemergency health care service is offered to the covered person and prior to the provision of the nonemergency health care service to the covered person.

2. The health care provider may assist the covered person in obtaining the good-faith estimate.

3. If the health care provider is not able to comply with the requirements set forth in subparagraph 1.b. of this paragraph due to the provider's inability to predict the health care service or diagnostic code for the health care service that is to be offered or provided to the covered person, the health care provider shall disclose what is known about the proposed nonemergency health care service within the time required, including any facility fees that may be required by a facility at which the provider proposes to provide the nonemergency health care service. The health care provider shall also disclose the incomplete nature of the information provided to the covered person and inform the covered person of his or her ability to obtain updated information from the provider once additional information is obtained by the provider; and

(c) The health care provider shall post the notifications required by subsection (4) of Section 6 of this Act;

(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 4. KRS 304.17A-505 is amended to read as follows:

An insurer shall disclose in writing to a covered person~~[and an insured or enrollee]~~, in a manner consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its health benefit plan and shall promptly provide the covered person~~[and enrollee]~~ with written notification of any change in the terms and conditions prior to the effective date of the change. The insurer shall provide the required information at the time of enrollment and upon request thereafter.

(1) The information required to be disclosed under this section shall include a description of:

(a) Covered services and benefits to which the~~[enrollee or other]~~ covered person is entitled***, including the notices to covered persons that are required by subsection (2) of Section 2 of this Act***;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review;

2. An internal appeal of a utilization review made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit or the denial of payment for a health care service, and the procedure to initiate an internal appeal; and

3. An external review and the procedure to initiate the external review process;

(h) Measures in place to ensure the confidentiality of the relationship between ***a covered person*** ~~[an enrollee]~~ and a health care provider;

(i) Other information as the commissioner shall require by administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured~~[or enrollee]~~, a complete drug formulary; and

(k) A statement informing the insured~~[or enrollee]~~ that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer.

(2) The insurer shall file the information required under this section with the department.

➔Section 5. KRS 304.17A-527 is amended to read as follows:

(1) ***An insurer that offers*** a managed care plan 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 ***shall*** ~~[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 ***the enrollee's*** ~~[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]~~ ***shall***~~[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 the amendment pursuant to KRS 304.17A-577;~~[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 ***shall***~~[must]~~ meet all requirements of this subtitle and that all~~[such]~~ subcontract agreements shall be filed with the commissioner in accordance with this subsection***; and***

(f) The clauses required by subsection 7(b) and (c) of Section 3 of this Act.

(2) An insurer that offers a managed care plan shall file with the department a description of the incentive program required by subsection (2) of Section 2 of this Act. The filing shall be made prior to offering the program to any enrollee and in a manner and form prescribed by the commissioner. The filing, and any supporting documentation, shall be confidential until it is approved or disapproved by the commissioner.

(3)~~[(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 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 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.

(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 6. A NEW SECTION OF KRS CHAPTER 367 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Covered person" means:

1. A "covered person" as defined in Section 1 of this Act; or

2. An individual who receives Medicaid benefits pursuant to KRS Chapter 205;

(b) "Health care provider" or "provider" has the same meaning as in Section 1 of this Act;

(c) "Health care service" has the same meaning as in Section 1 of this Act;

(d) "Insurer" means:

1. An "insurer" as defined in Section 1 of this Act; or

2. The Department for Medicaid Services or a managed care organization contracted to provide Medicaid services pursuant to KRS Chapter 205;

(e) "Nonemergency health care service" has the same meaning as in Section 2 of this Act; and

(f) "Nonparticipating provider" means a provider that has not entered into an agreement to provide health care services to a covered person.

(2) (a) Upon request by a covered person who is a patient or a prospective patient of a nonparticipating provider, the nonparticipating provider shall disclose to the covered person the price that will be collected for a proposed nonemergency health care service, including any facility fees that may be required by a facility at which the nonparticipating provider proposes to provide the nonemergency health care service.

(b) Except as otherwise provided in subsection (3) of this section, the disclosure required by paragraph (a) of this subsection shall be made within two (2) working days of the covered person's request and prior to the provision of a nonemergency health care service to the covered person.

(3) If the nonparticipating provider is not able to comply with the requirements set forth in subsection (2)(b) of this section due to the nonparticipating provider's inability to predict the health care service or diagnostic code for the health care service that is to be offered or provided to the covered person, the nonparticipating provider shall disclose what is known about the proposed

nonemergency health care service within the time required, including any facility fees that may be required by a facility at which the nonparticipating provider proposes to provide the nonemergency health care service. The nonparticipating provider shall also disclose the incomplete nature of the information provided to the covered person and inform the covered person of his or her ability to obtain updated information from the nonparticipating provider once additional information is obtained by the provider.

(4) Health care providers shall post in an area that is visible to the provider's patients and prospective patients the following notifications:

(a) That covered persons may obtain sufficient information from the provider about nonemergency health care services offered or provided by the provider to allow the covered person to receive assistance from the covered person's insurer to assist the person in comparing out-of-pocket and allowed amounts paid for the covered person's health care to different health care providers for similar services.

(b) That, for each health care service being offered or provided, the following information may be obtained from the provider pursuant to paragraph (a) of this subsection:

1. A common procedural terminology code or other coding system commonly used by the health care provider and accepted as a national standard for billing; and

2. A plain language description of the health care service.

(c) That covered persons may obtain health care services from different providers regardless of a referral or recommendation from a provider;

(d) That seeing a high-value provider, either their currently referred provider or a different provider, may result in an incentive payment to the covered person if the person follows the procedures communicated by the person's

insurer;

(e) An outline of the parameters of potential incentives authorized by Section 2 of this Act;

(f) That the covered person's insurer is required to provide the person an estimate of out-of-pocket costs and allowed amounts paid for the person's care to different providers for similar services via a Web site and a toll-free telephone number; and

(g) Any other information that informs covered persons of the price transparency tools required by Section 2 of this Act.

(5) (a) A health care provider that is not a hospital licensed as a health facility pursuant to KRS Chapter 216B shall disclose and make available to the public in a single document, either electronically or by posting conspicuously on the provider's Web site, if one exists, the prices charged, prior to the negotiation of any discounts and assuming no medical complications, for the twenty-five (25) most common health care services the provider renders.

(b) For each price disclosed, the provider shall identify the health care service in both:

1. A common procedural terminology code or other coding system commonly used by the health care provider and accepted as a national standard for billing; and

2. A plain language description.

(c) The prices disclosed shall be updated as frequently as the health care provider deems appropriate, but at least annually.

(6) (a) A health care provider that is a hospital licensed as a health facility pursuant to KRS Chapter 216B shall disclose and make available to the public in a single document, either electronically or by posting

conspicuously on the provider's Web site, if one exists, the prices charged, prior to the negotiation of any discounts and assuming no medical complications, for the seventy-five (75) most common inpatient health care services and the seventy-five (75) most common outpatient health care services, as grouped by Medicare diagnosis-related group, rendered by the hospital.

(b) The prices disclosed shall be updated on a quarterly basis.

(7) Any price information disclosed pursuant to subsection (5) or (6) of this section shall include the following disclaimers:

(a) The information provided is an estimate and does not constitute a legally binding charge for a health care service provided to a specific consumer; and

(b) The actual charge for a health care service is dependent on the circumstances at the time the health care service is rendered.

(8) The Attorney General may promulgate any administrative regulations that are necessary to interpret and implement this section.

➔SECTION 7. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

Notwithstanding any provision of law to the contrary, the Department for Medicaid Services or a managed care organization contracted to provide Medicaid services shall:

(1) Develop and implement the incentive program set forth in subsection (2) of Section 2 of this Act for Medicaid recipients who elect to receive a comparable health care service;

(2) Establish the interactive mechanism set forth in subsection (3) of Section 2 of this Act for Medicaid recipients;

(3) Provide the coverage required in subsection (4) of Section 2 of this Act to Medicaid recipients; and

(4) Include in any agreements it enters into with providers for the provision of health care services to Medicaid recipients the provisions set forth in subsection (7)(b) and (c) of Section 3 of this Act.

➔Section 8. KRS 304.17A-096 is amended to read as follows:

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group, and employer-organized association markets. A basic health benefit plan shall cover 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.

(2) An insurer that offers a basic health benefit plan shall be required to offer health benefit plans as defined in KRS 304.17A-005~~[(22)]~~.

(3) An insurer in the individual, small group, or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health benefit plan shall include coverage for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic benefits as provided in KRS 304.17A-171, mammograms as provided in KRS 304.17A-133, and those mandated benefits specified under federal law.

(4) Notwithstanding any other provisions of this section, mandated benefits excluded from coverage shall not be deemed to include the payment, indemnity, or reimbursement of specified health care providers for specific health care services.

➔Section 9. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high-risk individuals rather than using the criteria established in KRS 304.17A-005~~[(24)]~~ and 304.17A-280 for high-cost conditions.

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

➔Section 10. KRS 304.17B-001 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Administrator" is defined in KRS 304.9-051~~[(1)]~~;

(2) "Agent" is defined in KRS 304.9-020;

(3) "Assessment process" means the process of assessing and allocating guaranteed acceptance program losses or Kentucky Access funding as provided for in KRS 304.17B-021;

(4) "Authority" means the Kentucky Health Care Improvement Authority;

(5) "Case management" means a process for identifying an enrollee with specific health care needs and interacting with the enrollee and their respective health care providers in order to facilitate the development and implementation of a plan that efficiently uses health care resources to achieve optimum health outcome;

(6)~~["Commissioner" is defined in KRS 304.1-050(1);~~

~~(7) "Department" is defined in KRS 304.1-050(2);~~

~~(8)]~~ "Earned premium" means the portion of premium paid by an insured that has been allocated to the insurer's loss experience, expenses, and profit year to date;

(7)~~[(9)]~~ "Enrollee" means a person who is enrolled in a health benefit plan offered under Kentucky Access;

(8)~~[(10)]~~ "Eligible individual" is defined in KRS 304.17A-005~~[(11)]~~;

(9)~~[(11)]~~ "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(10)~~[(12)]~~ "Guaranteed acceptance program participating insurer" means an insurer that offered health benefit plans through December 31, 2000, in the individual market to guaranteed acceptance program qualified individuals;

(11)~~[(13)]~~ "Health benefit plan" is defined in KRS 304.17A-005~~[(22)]~~;

(12)~~[(14)]~~ "High-cost condition" means 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's 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, Wilson's disease, chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the

bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation period for a newborn child, and low birth weight of a newborn child;

(13) ~~[(15)]~~ "Incurred losses" means for Kentucky Access the excess of claims paid over premiums received;

(14) ~~[(16)]~~ "Insurer" is defined in KRS 304.17A-005~~[(27)]~~;

(15) ~~[(17)]~~ "Kentucky Access" means the program established in accordance with KRS 304.17B-001 to 304.17B-031;

(16) ~~[(18)]~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

(17) ~~[(19)]~~ "Kentucky Health Care Improvement Authority" means the board established to administer the program initiatives listed in KRS 304.17B-003(5);

(18) ~~[(20)]~~ "Kentucky Health Care Improvement Fund" means the fund established for receipt of the Kentucky tobacco master settlement moneys for program initiatives listed in KRS 304.17B-003~~[(5)]~~;

(19) ~~[(21)]~~ "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

(20) ~~[(22)]~~ "Medicaid" means coverage in accordance with Title XIX of the Social Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

(21) ~~[(23)]~~ "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

(22) ~~[(24)]~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~[(6)]~~;

(23) ~~[(25)]~~ "Standard health benefit plan" means a health benefit plan that meets the requirements of KRS 304.17A-250;

(24) ~~[(26)]~~ "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(25) ~~[(27)]~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employer-controlled or bona fide associations; and

(26) ~~[(28)]~~ "Utilization management" is defined in KRS 304.17A-500~~[(12)]~~.

➔Section 11. KRS 304.17B-015 is amended to read as follows:

(1) Any individual who is an eligible individual and a resident of Kentucky is eligible for coverage under Kentucky Access, except as specified in paragraphs (a), (b), (d), and (e) of subsection (4) of this section.

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in KRS 304.17B-001.

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3) year period and may be used by the enrollee to obtain insurance in the regular individual market.

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) 1. The individual has, or is eligible for, on the effective date of coverage under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section; or

2. For ***eligible*** individuals ***as defined in***~~[meeting the requirements of]~~ KRS 304.17A-005~~[(11)]~~, the individual has, or is eligible for, on the effective date of coverage under Kentucky Access, coverage under a group health plan.

An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible for" includes any individual and an individual's spouse or dependent who was eligible for coverage but waived that coverage. That individual and the individual's spouse or dependent shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the department;

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs; or

(f) The individual's premium, deductible, coinsurance, or copayment is partially or entirely paid or reimbursed by an individual or entity other than the individual or the individual's parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, grandchild, guardian, or court-appointed payor.

(5) The coverage of any person who ceases to meet the requirements of this section or the requirements of any administrative regulation promulgated under this subtitle may be terminated.

➔Section 12. KRS 304.17B-033 is amended to read as follows:

(1) No less than annually, the Health Insurance Advisory Council shall review the list of high-cost conditions established under KRS 304.17B-001~~[(14)]~~ and recommend changes to the commissioner. The commissioner may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the commissioner deems appropriate. The council, in making recommendations, and the commissioner, in making changes, shall consider, among other things, actual claims and losses on each diagnosis and advances in treatment of high-cost conditions.

(2) The commissioner may by administrative regulation add to or delete from the list of high-cost conditions for Kentucky Access.

➔Section 13. KRS 304.17C-010 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "At the time of enrollment" means the same as defined in KRS 304.17A-005~~[(2)]~~;

(2) "Enrollee" means an individual who is enrolled in a limited health service benefit plan;

(3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-005~~[(23)]~~;

(4) "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, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit

plan; and

(5) "Limited health service benefit plan" means any policy or certificate that provides services for dental, vision, mental health, substance abuse, chiropractic, pharmaceutical, podiatric, or other such services as may be determined by the commissioner to be offered under a limited health service benefit plan. A limited health service benefit plan shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the plan.

➔Section 14. KRS 304.38A-010 is amended to read as follows:

As used in this subtitle, unless the context requires otherwise:

(1) "Enrollee" means an individual who is enrolled in a limited health services benefit plan;

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in KRS 304.17C-010 unless exempted by the commissioner;

(3) "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, chiropractic services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service shall not include hospital, medical, surgical, or emergency services except as these services are provided incidental to the limited health services set forth in this subsection;

(4) "Limited health service contract" means any contract entered into by a limited health service organization with a policyholder to provide limited health services;

(5) "Limited health service organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange limited

health service or services to enrollees. A limited health service organization does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited health service organization, health maintenance organization, or a health insurer; and

(6) "Provider" means the same as defined in KRS 304.17A-005~~[(23)]~~.

➔Section 15. KRS 304.39-241 is amended to read as follows:

An insured may direct the payment of benefits among the different elements of loss, if the direction is provided in writing to the reparation obligor. A reparation obligor shall honor the written direction of benefits provided by an insured on a prospective basis. The insured may also explicitly direct the payment of benefits for related medical expenses already paid arising from a covered loss to reimburse:

(1) A health benefit plan as defined by KRS 304.17A-005~~[(22)]~~;

(2) A limited health service benefit plan as defined by KRS 304.17C-010;

(3) Medicaid;

(4) Medicare; or

(5) A Medicare supplement provider.

➔Section 16. This Act takes effect on January 1, 2019.