

1 AN ACT relating to surprise billing.

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

3 ➔Section 1. KRS 304.17A-500 is amended to read as follows:

4 As used in KRS 304.17A-500 to 304.17A-590, unless the context requires otherwise:

- 5 (1) "Areas other than urban areas" means a classification code that does not meet the
6 definition of urban area;
- 7 (2) "Contract holder" means an employer or organization that purchases a health benefit
8 plan;
- 9 (3) "Covered person" means a person on whose behalf an insurer offering the plan is
10 obligated to pay benefits or provide services under the health benefit plan~~insurance~~
11 ~~policy~~;
- 12 (4) "Emergency medical condition" means:
- 13 (a) A medical condition manifesting itself by acute symptoms of sufficient
14 severity, including severe pain, that a prudent layperson would reasonably
15 have cause to believe constitutes a condition that the absence of immediate
16 medical attention could reasonably be expected to result in:
- 17 1. Placing the health of the individual or, with respect to a pregnant
18 woman, the health of the woman or her unborn child, in serious
19 jeopardy;
- 20 2. Serious impairment to bodily functions; or
- 21 3. Serious dysfunction of any bodily organ or part; or
- 22 (b) With respect to a pregnant woman who is having contractions:
- 23 1. A situation in which there is inadequate time to effect a safe transfer to
24 another hospital before delivery; or
- 25 2. A situation in which transfer may pose a threat to the health or safety of
26 the woman or the unborn child;
- 27 (5) "Enrollee" means a person who is enrolled in a plan offered by a health maintenance

1 organization as defined in KRS 304.38-030(5);

2 **(6) "Facility" means "health facility" as defined in KRS 216B.015;**

3 ~~(7)(6)~~ "Grievance" means a written complaint submitted by or on behalf of an
4 enrollee;

5 ~~(8)(7)~~ "Health insurance policy" means "health benefit plan" as defined in KRS
6 304.17A-005;

7 **(9) "In-network facility" means a facility that is a participating health care provider;**

8 ~~(10)(8)~~ "Insurer" has the meaning provided in KRS 304.17A-005;

9 ~~(11)(9)~~ "Managed care plan" means a health **benefit plan**~~[insurance policy]~~ that
10 integrates the financing and delivery of appropriate health care services to enrollees
11 by arrangements with participating **health care** providers who are selected to
12 participate on the basis of explicit standards to furnish a comprehensive set of
13 health care services and financial incentives for enrollees to use the participating
14 **health care** providers and procedures provided for in the plan;

15 ~~(12)(10)~~ "Participating health care provider" means a health care provider that has
16 entered into an agreement with **a covered person's**~~[an]~~ insurer to provide health
17 care services **to the covered person**;

18 ~~(13)(11)~~ "Quality assurance or improvement" means the ongoing evaluation by a
19 managed care plan of the quality of health care services provided to its enrollees;

20 ~~(14)(12)~~ "Record" means any written, printed, or electronically recorded material
21 maintained by a provider in the course of providing health **care** services to a patient
22 concerning the patient and the services provided. "Record" also includes the
23 substance of any communication made by a patient to a provider in confidence
24 during or in connection with the provision of health **care** services to a patient or
25 information otherwise acquired by the provider about a patient in confidence and in
26 connection with the provision of health **care** services to a patient;

27 ~~(15)(13)~~ "Risk sharing arrangement" means any agreement that allows an insurer to

1 share the financial risk of providing health care services to enrollees or insureds
 2 with another entity or provider where there is a chance of financial loss to the entity
 3 or provider as a result of the delivery of a service. A risk sharing arrangement shall
 4 not include a reinsurance contract with an accredited or admitted reinsurer;

5 ~~(16)~~~~(14)~~ "Urban area" means a classification code whereby the zip code population
 6 density is greater than three thousand (3,000) persons per square mile; and

7 ~~(17)~~~~(15)~~ "Utilization management" means a system for reviewing the appropriate and
 8 efficient allocation of health care services under a health ~~benefit~~~~benefits~~ plan
 9 according to specified guidelines, in order to recommend or determine whether, or
 10 to what extent, a health care service given or proposed to be given to a covered
 11 person should or will be reimbursed, covered, paid for, or otherwise provided under
 12 the plan. The system may include preadmission certification, the application of
 13 practice guidelines, continued stay review, discharge planning, preauthorization of
 14 ambulatory care procedures, and retrospective review.

15 ➔SECTION 2. A NEW SECTION OF KRS 304.17A-500 TO 304.17A-590 IS
 16 CREATED TO READ AS FOLLOWS:

17 **(1) (a) As used in this section, "covered health care services" means health care**
 18 **services that are covered by a covered person's health benefit plan, but:**

19 **1. Are not eligible for payment under the plan unless the services are**
 20 **provided by a participating health care provider; or**

21 **2. Are eligible for payment under the plan at terms that are more**
 22 **favorable to the covered person if the services are provided by a**
 23 **participating health care provider.**

24 **(b) "Covered health care services" shall not include coverage required by**
 25 **Section 6 of this Act for emergency medical conditions or emergency**
 26 **department screening and stabilization.**

27 **(2) All health benefit plans issued or renewed on or after the effective date of this Act**

1 shall provide coverage for covered health care services by a nonparticipating
 2 health care provider to a covered person at an in-network facility.

3 (3) For health care services covered pursuant to this section:

4 (a) An insurer offering a health benefit plan shall:

5 1. Reimburse the nonparticipating provider at the in-network maximum
 6 allowable rate for the health care service less any applicable in-
 7 network cost sharing owed by the covered person;

8 2. Send the reimbursement directly to the nonparticipating provider; and

9 3. Along with the reimbursement required by this paragraph, notify the
 10 nonparticipating health care provider of any coinsurance, deductibles,
 11 copayments, and other out-of-pocket expenses that would be owed by
 12 the covered person for the health care services under the covered
 13 person's health benefit plan if the services were provided by a
 14 participating provider.

15 (b) A nonparticipating health care provider shall not collect, or attempt to
 16 collect, any payment amount from a covered person other than for any
 17 applicable in-network cost sharing, including coinsurance, deductibles,
 18 copayments, and other out-of-pocket expenses that would be owed by the
 19 covered person under the covered person's health benefit plan for the
 20 services received if the services were provided by a participating provider.

21 (4) Except as provided in subsection (3) of this section relating to reimbursement
 22 rates, all claims and reimbursements covered by this section shall be subject to
 23 KRS 304.17A-700 to 304.17A-730, KRS 304.14-135, and 304.99-123.

24 ➔Section 3. KRS 304.17A-254 is amended to read as follows:

25 An insurer that offers a health benefit plan that is not a managed care plan as defined in
 26 Section 1 of this Act, but that provides financial incentives for a covered person to access
 27 a network of providers shall:

- 1 (1) Notify the covered person, in writing, of the availability of a printed document, in a
2 manner consistent with KRS 304.14-420 to 304.14-450, containing the following
3 information at the time of enrollment and upon request:
- 4 (a) A current directory of the in-network providers from which the covered
5 person may access covered services at a financially beneficial rate. The
6 directory shall, at a minimum, provide the name, type of provider,
7 professional office address, telephone number, and specialty designations of
8 the network provider, if any; and
- 9 (b) In addition to making the information available in a printed document, an
10 insurer may also make the information available in an accessible electronic
11 format;
- 12 (2) Assure that contracts with the providers in the network contain a hold harmless
13 agreement under which the covered person ~~shall~~^{will} not be balanced billed by the
14 in-network provider except for deductibles, co-pays, coinsurance amounts, and
15 noncovered benefits;
- 16 (3) File with the department a copy of the directory required under subsection (1) of
17 this section;
- 18 (4) Have a process for the selection of health care providers who will be on the insurer's
19 list of participating providers, with written policies and procedures for review and
20 approval used by the insurer. The insurer shall establish minimum professional
21 requirements for participating health care providers. An insurer ~~shall~~^{may} not
22 discriminate against a provider solely on the basis of the provider's license by the
23 state;
- 24 (5) Not contract with a health care provider to limit the provider's disclosure to a
25 covered person, or to another person on behalf of a covered person, of any
26 information relating to the covered person's medical condition or treatment options;
- 27 (6) Not penalize a health care provider, or terminate a health care provider's contract

1 with the insurer, because the provider discusses medically necessary or appropriate
2 care with a covered person or another person on behalf of a covered person. The
3 health care provider may:

4 (a) Not be prohibited by the insurer from discussing all treatment options with the
5 covered person; and

6 (b) Disclose to the covered person or to another person on behalf of a covered
7 person other information determined by the health care provider to be in the
8 best interests of the covered person;

9 (7) Include in any agreements it enters into with providers for the provision of health
10 care services:

11 (a) A clause stating that the insurer ~~shall~~^{will}, upon request of a health care
12 provider, provide or make available to a health care provider, when
13 contracting or renewing an existing contract with such provider, the payment
14 or fee schedules or other information sufficient to enable the health care
15 provider to determine the manner and amount of payments under the contract
16 for the health care provider's services prior to the final execution or renewal of
17 the contract and shall provide any change in such schedules at least ninety
18 (90) days prior to the effective date of the amendment pursuant to KRS
19 304.17A-577; and

20 (b) If the provider is a health facility as defined in KRS 216B.015, a clause
21 requiring that if the provider enters into any subcontract agreement with
22 another provider for the provision of licensed health care services, either in-
23 network or out-of-network to a covered person, the subcontract agreement
24 shall:

25 1. Require the subcontracted provider, regardless of the subcontracted
26 provider's status as a participating or nonparticipating provider, to
27 accept as payment in full for any health care services furnished by the

- 1 subcontracted provider at the health facility, the reimbursement
 2 amount set forth in subsection (3) of Section 2 of this Act; and
 3 2. Include notice to the subcontracted provider of the reimbursement
 4 limitations of subparagraph 1.a of this paragraph; and
 5 3. Require the subcontracted provider to comply with all requirements of
 6 this subtitle.

- 7 (8) Establish a policy governing the removal of and withdrawal by health care providers
 8 from the provider network that includes the following:
- 9 (a) The insurer shall inform a participating health care provider of the insurer's
 10 removal and withdrawal policy at the time the insurer contracts with the health
 11 care provider to participate in the provider network, and when changed
 12 thereafter;
- 13 (b) If a participating health care provider's participation will be terminated or
 14 withdrawn prior to the date of the termination of the contract as a result of a
 15 professional review action, the insurer and participating health care provider
 16 shall comply with the standards in 42 U.S.C. sec. 11112; and
- 17 (c) If the insurer finds that a health care provider represents an imminent danger
 18 to an individual patient or to the public health, safety, or welfare, the medical
 19 director shall promptly notify the appropriate professional state licensing
 20 board; and
- 21 (9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS
 22 304.17A-700 to 304.17A-730.

23 ➔Section 4. KRS 304.17A-527 is amended to read as follows:

- 24 (1) A managed care plan shall file with the commissioner sample copies of any
 25 agreements it enters into with providers for the provision of health care services.
 26 The commissioner shall promulgate administrative regulations prescribing the
 27 manner and form of the filings required. The agreements shall include the

1 following:

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

4 1. Nonpayment of moneys due the providers by the managed care plan,

5 2. Insolvency of the managed care plan, or

6 3. Breach of the agreement,

7 bill, charge, collect a deposit, seek compensation, remuneration, or
8 reimbursement from, or have any recourse against the~~subscriber, dependent~~
9 ~~of subscriber,~~ enrollee~~,~~ or any persons acting on the enrollee's~~their~~ behalf,
10 for services provided in accordance with the provider agreement. This
11 provision shall not prohibit collection of deductible amounts, copayment
12 amounts, coinsurance amounts, and amounts for noncovered services;

13 (b) A continuity of care clause that states that if an agreement between the
14 provider and the managed care plan is terminated for any reason, other than a
15 quality of care issue or fraud, the managed care plan~~insurer~~ shall continue
16 to provide services and~~the plan shall continue to~~ reimburse the provider in
17 accordance with the agreement until the~~subscriber, dependent of the~~
18 ~~subscriber, or the~~ enrollee is discharged from an inpatient facility, or the
19 active course of treatment is completed, whichever time is greater, and in the
20 case of a pregnant woman, services shall continue to be provided through the
21 end of the post-partum period if the pregnant woman is in her fourth or later
22 month of pregnancy at the time the agreement is terminated;

23 (c) A survivorship clause that states the hold harmless clause and continuity of
24 care clause shall survive the termination of the agreement between the
25 provider and the managed care plan;

26 (d) A clause stating that the~~insurer issuing a~~ managed care plan shall~~will~~,
27 upon request of a participating provider, provide or make available to a

1 participating provider, when contracting or renewing an existing contract with
 2 such provider, the payment or fee schedules or other information sufficient to
 3 enable the provider to determine the manner and amount of payments under
 4 the contract for the provider's services prior to the final execution or renewal
 5 of the contract and shall provide any change in such schedules at least ninety
 6 (90) days prior to the effective date of the amendment pursuant to KRS
 7 304.17A-577; and

- 8 (e) **1.** A clause requiring that if a provider enters into any subcontract
 9 agreement with another provider to provide their licensed health care
 10 services to the ~~subscriber, dependent of the subscriber, or~~ enrollee of a
 11 managed care plan where the subcontracted provider will bill the
 12 managed care plan or ~~subscriber or~~ enrollee directly for the
 13 subcontracted services, the subcontract agreement **shall:**

14 **a. Require the subcontracted provider to comply with** ~~must meet~~ all
 15 requirements of this subtitle; and ~~that all such subcontract~~
 16 ~~agreements~~

17 **b.** Shall be filed with the commissioner in accordance with this
 18 subsection.

19 **2. If the participating provider is a health facility as defined in KRS**
 20 **216B.015, a clause requiring that if the participating provider enters**
 21 **into any subcontract agreement with another provider for the**
 22 **provision of licensed health care services, either in-network or out-of-**
 23 **network to an enrollee, the subcontract agreement shall:**

24 **a. Require the subcontracted provider, regardless of the**
 25 **subcontracted provider's status as a participating or**
 26 **nonparticipating provider, to accept as payment in full for any**
 27 **health care services furnished by the subcontracted provider at**

1 the health facility, the reimbursement amount set forth in
 2 subsection (3) of Section 2 of this Act; and
 3 b. Include notice to the subcontracted provider of the
 4 reimbursement limitations of subparagraph 1.a of this
 5 paragraph.

- 6 (2) An insurer that offers a health benefit plan that enters into any risk-sharing
 7 arrangement or subcontract agreement shall file a copy of the arrangement with the
 8 commissioner. The insurer shall also file the following information regarding the
 9 risk-sharing arrangement:
- 10 (a) The number of enrollees affected by the risk-sharing arrangement;
 - 11 (b) The health care services to be provided to an enrollee under the risk-sharing
 12 arrangement;
 - 13 (c) The nature of the financial risk to be shared between the insurer and entity or
 14 provider, including but not limited to the method of compensation;
 - 15 (d) Any administrative functions delegated by the insurer to the entity or provider.
 16 The insurer shall describe a plan to ensure that the entity or provider will
 17 comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated
 18 administrative functions; and
 - 19 (e) The insurer's oversight and compliance plan regarding the standards and
 20 method of review.
- 21 (3) Nothing in this section shall be construed as requiring an insurer to submit the
 22 actual financial information agreed to between the insurer and the entity or provider.
 23 The commissioner shall have access to a specific risk sharing arrangement with an
 24 entity or provider upon request to the insurer. Financial information obtained by the
 25 department shall be considered to be a trade secret and shall not be subject to KRS
 26 61.872 to 61.884.

27 ➔Section 5. KRS 304.17A-565 is amended to read as follows:

1 ~~[The commissioner shall enforce]~~ The provisions of KRS 304.17A-500 to 304.17A-
 2 590:~~[304.17A-570 and]~~

3 (1) Shall *be enforced by the commissioner; and*~~[adopt administrative regulations~~
 4 ~~necessary to carry out the provisions of KRS 304.17A-500 to 304.17A-570.]~~

5 (2) *Shall not be construed to preempt or supersede any other rights or remedies*
 6 *available to covered persons under state or federal law.*

7 ➔Section 6. KRS 304.17A-580 is amended to read as follows:

8 (1) An insurer offering health benefit plans shall educate its insureds about the
 9 availability, location, and appropriate use of emergency and other medical services,
 10 cost-sharing provisions for emergency services, and the availability of care outside
 11 an emergency department.

12 (2) An insurer offering health benefit plans shall cover emergency medical conditions
 13 and shall pay for emergency department screening and stabilization services both in-
 14 network and out-of-network without prior authorization for conditions that
 15 reasonably appear to a prudent layperson to constitute an emergency medical
 16 condition based on the patient's presenting symptoms and condition. An insurer
 17 shall be prohibited from denying the emergency room services and altering the level
 18 of coverage or cost-sharing requirements for any condition or conditions that
 19 constitute an emergency medical condition~~[as defined in KRS 304.17A-500].~~

20 (3) Emergency department personnel shall contact a patient's primary care provider or
 21 insurer, as appropriate, as quickly as possible to discuss follow-up and
 22 poststabilization care and promote continuity of care.

23 (4) *For emergency medical conditions and emergency department screening and*
 24 *stabilization services covered pursuant to this section, if the emergency medical*
 25 *condition was treated by or the screening and stabilization services were provided*
 26 *by a nonparticipating provider at a health facility, as defined in KRS 216B.015,*
 27 *that is a participating provider:*

1 (a) A covered person's insurer shall:

- 2 1. Reimburse a nonparticipating provider at the in-network maximum
3 allowable rate for the services provided less any applicable in-network
4 cost sharing owed by the covered person;
5 2. Send the reimbursement directly to the nonparticipating provider; and
6 3. Along with the reimbursement required by this paragraph, notify the
7 nonparticipating provider of any coinsurance, deductibles,
8 copayments, and other out-of-pocket expenses that would be owed by
9 the covered person for the screening and stabilization services under
10 the covered person's health benefit plan if the services were provided
11 by a participating provider.

12 (b) The nonparticipating health care provider:

- 13 1. Shall not collect, or attempt to collect, any payment amount from a
14 covered person other than for any applicable in-network cost sharing,
15 including coinsurance, deductibles, copayments, and other out-of-
16 pocket expenses that would be owed by the covered person under the
17 covered person's health benefit plan for the services received if the
18 services were provided by a participating provider; and
19 2. Shall accept the reimbursement required by paragraph (a)1. of this
20 subsection plus any applicable in-network cost sharing owed by the
21 covered person as payment in full for services covered pursuant to this
22 section.

23 (5) Where a covered person with an emergency medical condition has been
24 stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of
25 1985 (COBRA), 42 U.S.C. secs. 300bb-1 et seq., in the emergency department of a
26 nonparticipating hospital, and an insurer under its health benefit plan requires
27 prior authorization for poststabilization treatment, approval or denial under the

1 *preauthorization requirement shall be provided in a timely manner appropriate to*
 2 *conditions of the patient and delivery of the services, but in no case to exceed two*
 3 *(2) hours from the time the request is made and all relevant information is*
 4 *provided. The insurer's failure to make a determination within the two (2) hour*
 5 *time frame shall constitute an authorization for the hospital to provide the*
 6 *medical service for which prior authorization was sought.*

7 *(6) A nonparticipating hospital providing emergency room services, poststabilization*
 8 *treatment, or both shall be paid at a rate negotiated between the nonparticipating*
 9 *hospital and the insurer. Nothing in this section is to be construed as requiring*
 10 *the payment of one hundred percent (100%) of the billed charges.*

11 ~~(7)(4)~~ Nothing in this section shall apply to accident-only, specified disease, hospital
 12 indemnity, Medicare supplement, long-term care, disability income, or other
 13 limited-benefit health insurance policies.

14 ➔Section 7. KRS 18A.225 is amended to read as follows:

- 15 (1) (a) The term "employee" for purposes of this section means:
- 16 1. Any person, including an elected public official, who is regularly
 17 employed by any department, office, board, agency, or branch of state
 18 government; or by a public postsecondary educational institution; or by
 19 any city, urban-county, charter county, county, or consolidated local
 20 government, whose legislative body has opted to participate in the state-
 21 sponsored health insurance program pursuant to KRS 79.080; and who
 22 is either a contributing member to any one (1) of the retirement systems
 23 administered by the state, including but not limited to the Kentucky
 24 Retirement Systems, Kentucky Teachers' Retirement System, the
 25 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is
 26 receiving a contractual contribution from the state toward a retirement
 27 plan; or, in the case of a public postsecondary education institution, is an

- 1 individual participating in an optional retirement plan authorized by
2 KRS 161.567;
- 3 2. Any certified or classified employee of a local board of education;
- 4 3. Any elected member of a local board of education;
- 5 4. Any person who is a present or future recipient of a retirement
6 allowance from the Kentucky Retirement Systems, Kentucky Teachers'
7 Retirement System, the Legislators' Retirement Plan, the Judicial
8 Retirement Plan, or the Kentucky Community and Technical College
9 System's optional retirement plan authorized by KRS 161.567, except
10 that a person who is receiving a retirement allowance and who is age
11 sixty-five (65) or older shall not be included, with the exception of
12 persons covered under KRS 61.702(4)(c), unless he or she is actively
13 employed pursuant to subparagraph 1. of this paragraph; and
- 14 5. Any eligible dependents and beneficiaries of participating employees
15 and retirees who are entitled to participate in the state-sponsored health
16 insurance program;
- 17 (b) The term "health benefit plan" for the purposes of this section means a health
18 benefit plan as defined in KRS 304.17A-005;
- 19 (c) The term "insurer" for the purposes of this section means an insurer as defined
20 in KRS 304.17A-005; and
- 21 (d) The term "managed care plan" for the purposes of this section means a
22 managed care plan as defined in KRS 304.17A-500.
- 23 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
24 recommendation of the secretary of the Personnel Cabinet, shall procure, in
25 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
26 from one (1) or more insurers authorized to do business in this state, a group
27 health benefit plan that may include but not be limited to health maintenance

1 organization (HMO), preferred provider organization (PPO), point of service
2 (POS), and exclusive provider organization (EPO) benefit plans encompassing
3 all or any class or classes of employees. With the exception of employers
4 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
5 employers of any class of employees or former employees shall enter into a
6 contract with the Personnel Cabinet prior to including that group in the state
7 health insurance group. The contracts shall include but not be limited to
8 designating the entity responsible for filing any federal forms, adoption of
9 policies required for proper plan administration, acceptance of the contractual
10 provisions with health insurance carriers or third-party administrators, and
11 adoption of the payment and reimbursement methods necessary for efficient
12 administration of the health insurance program. Health insurance coverage
13 provided to state employees under this section shall, at a minimum, contain
14 the same benefits as provided under Kentucky Kare Standard as of January 1,
15 1994, and shall include a mail-order drug option as provided in subsection
16 (13) of this section. All employees and other persons for whom the health care
17 coverage is provided or made available shall annually be given an option to
18 elect health care coverage through a self-funded plan offered by the
19 Commonwealth or, if a self-funded plan is not available, from a list of
20 coverage options determined by the competitive bid process under the
21 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
22 during annual open enrollment.

23 (b) The policy or policies shall be approved by the commissioner of insurance and
24 may contain the provisions the commissioner of insurance approves, whether
25 or not otherwise permitted by the insurance laws.

26 (c) Any carrier bidding to offer health care coverage to employees shall agree to
27 provide coverage to all members of the state group, including active

1 employees and retirees and their eligible covered dependents and
2 beneficiaries, within the county or counties specified in its bid. Except as
3 provided in subsection (20) of this section, any carrier bidding to offer health
4 care coverage to employees shall also agree to rate all employees as a single
5 entity, except for those retirees whose former employers insure their active
6 employees outside the state-sponsored health insurance program.

7 (d) Any carrier bidding to offer health care coverage to employees shall agree to
8 provide enrollment, claims, and utilization data to the Commonwealth in a
9 format specified by the Personnel Cabinet with the understanding that the data
10 shall be owned by the Commonwealth; to provide data in an electronic form
11 and within a time frame specified by the Personnel Cabinet; and to be subject
12 to penalties for noncompliance with data reporting requirements as specified
13 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
14 to protect the confidentiality of each individual employee; however,
15 confidentiality assertions shall not relieve a carrier from the requirement of
16 providing stipulated data to the Commonwealth.

17 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
18 for timely analysis of data received from carriers and, to the extent possible,
19 provide in the request-for-proposal specifics relating to data requirements,
20 electronic reporting, and penalties for noncompliance. The Commonwealth
21 shall own the enrollment, claims, and utilization data provided by each carrier
22 and shall develop methods to protect the confidentiality of the individual. The
23 Personnel Cabinet shall include in the October annual report submitted
24 pursuant to the provisions of KRS 18A.226 to the Governor, the General
25 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
26 financial stability of the program, which shall include but not be limited to
27 loss ratios, methods of risk adjustment, measurements of carrier quality of

1 service, prescription coverage and cost management, and statutorially required
2 mandates. If state self-insurance was available as a carrier option, the report
3 also shall provide a detailed financial analysis of the self-insurance fund
4 including but not limited to loss ratios, reserves, and reinsurance agreements.

5 (f) If any agency participating in the state-sponsored employee health insurance
6 program for its active employees terminates participation and there is a state
7 appropriation for the employer's contribution for active employees' health
8 insurance coverage, then neither the agency nor the employees shall receive
9 the state-funded contribution after termination from the state-sponsored
10 employee health insurance program.

11 (g) Any funds in flexible spending accounts that remain after all reimbursements
12 have been processed shall be transferred to the credit of the state-sponsored
13 health insurance plan's appropriation account.

14 (h) Each entity participating in the state-sponsored health insurance program shall
15 provide an amount at least equal to the state contribution rate for the employer
16 portion of the health insurance premium. For any participating entity that used
17 the state payroll system, the employer contribution amount shall be equal to
18 but not greater than the state contribution rate.

19 (3) The premiums may be paid by the policyholder:

20 (a) Wholly from funds contributed by the employee, by payroll deduction or
21 otherwise;

22 (b) Wholly from funds contributed by any department, board, agency, public
23 postsecondary education institution, or branch of state, city, urban-county,
24 charter county, county, or consolidated local government; or

25 (c) Partly from each, except that any premium due for health care coverage or
26 dental coverage, if any, in excess of the premium amount contributed by any
27 department, board, agency, postsecondary education institution, or branch of

1 state, city, urban-county, charter county, county, or consolidated local
2 government for any other health care coverage shall be paid by the employee.

3 (4) If an employee moves his place of residence or employment out of the service area
4 of an insurer offering a managed health care plan, under which he has elected
5 coverage, into either the service area of another managed health care plan or into an
6 area of the Commonwealth not within a managed health care plan service area, the
7 employee shall be given an option, at the time of the move or transfer, to change his
8 or her coverage to another health benefit plan.

9 (5) No payment of premium by any department, board, agency, public postsecondary
10 educational institution, or branch of state, city, urban-county, charter county,
11 county, or consolidated local government shall constitute compensation to an
12 insured employee for the purposes of any statute fixing or limiting the
13 compensation of such an employee. Any premium or other expense incurred by any
14 department, board, agency, public postsecondary educational institution, or branch
15 of state, city, urban-county, charter county, county, or consolidated local
16 government shall be considered a proper cost of administration.

17 (6) The policy or policies may contain the provisions with respect to the class or classes
18 of employees covered, amounts of insurance or coverage for designated classes or
19 groups of employees, policy options, terms of eligibility, and continuation of
20 insurance or coverage after retirement.

21 (7) Group rates under this section shall be made available to the disabled child of an
22 employee regardless of the child's age if the entire premium for the disabled child's
23 coverage is paid by the state employee. A child shall be considered disabled if he
24 has been determined to be eligible for federal Social Security disability benefits.

25 (8) The health care contract or contracts for employees shall be entered into for a period
26 of not less than one (1) year.

27 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of

1 State Health Insurance Subscribers to advise the secretary or his designee regarding
2 the state-sponsored health insurance program for employees. The secretary shall
3 appoint, from a list of names submitted by appointing authorities, members
4 representing school districts from each of the seven (7) Supreme Court districts,
5 members representing state government from each of the seven (7) Supreme Court
6 districts, two (2) members representing retirees under age sixty-five (65), one (1)
7 member representing local health departments, two (2) members representing the
8 Kentucky Teachers' Retirement System, and three (3) members at large. The
9 secretary shall also appoint two (2) members from a list of five (5) names submitted
10 by the Kentucky Education Association, two (2) members from a list of five (5)
11 names submitted by the largest state employee organization of nonschool state
12 employees, two (2) members from a list of five (5) names submitted by the
13 Kentucky Association of Counties, two (2) members from a list of five (5) names
14 submitted by the Kentucky League of Cities, and two (2) members from a list of
15 names consisting of five (5) names submitted by each state employee organization
16 that has two thousand (2,000) or more members on state payroll deduction. The
17 advisory committee shall be appointed in January of each year and shall meet
18 quarterly.

19 (10) Notwithstanding any other provision of law to the contrary, the policy or policies
20 provided to employees pursuant to this section shall not provide coverage for
21 obtaining or performing an abortion, nor shall any state funds be used for the
22 purpose of obtaining or performing an abortion on behalf of employees or their
23 dependents.

24 (11) Interruption of an established treatment regime with maintenance drugs shall be
25 grounds for an insured to appeal a formulary change through the established appeal
26 procedures approved by the Department of Insurance, if the physician supervising
27 the treatment certifies that the change is not in the best interests of the patient.

1 (12) Any employee who is eligible for and elects to participate in the state health
2 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any
3 one (1) of the state-sponsored retirement systems shall not be eligible to receive the
4 state health insurance contribution toward health care coverage as a result of any
5 other employment for which there is a public employer contribution. This does not
6 preclude a retiree and an active employee spouse from using both contributions to
7 the extent needed for purchase of one (1) state sponsored health insurance policy for
8 that plan year.

9 (13) (a) The policies of health insurance coverage procured under subsection (2) of
10 this section shall include a mail-order drug option for maintenance drugs for
11 state employees. Maintenance drugs may be dispensed by mail order in
12 accordance with Kentucky law.

13 (b) A health insurer shall not discriminate against any retail pharmacy located
14 within the geographic coverage area of the health benefit plan and that meets
15 the terms and conditions for participation established by the insurer, including
16 price, dispensing fee, and copay requirements of a mail-order option. The
17 retail pharmacy shall not be required to dispense by mail.

18 (c) The mail-order option shall not permit the dispensing of a controlled
19 substance classified in Schedule II.

20 ~~(14) The policy or policies provided to state employees or their dependents pursuant to~~
21 ~~this section shall provide coverage for obtaining a hearing aid and acquiring hearing~~
22 ~~aid-related services for insured individuals under eighteen (18) years of age, subject~~
23 ~~to a cap of one thousand four hundred dollars (\$1,400) every thirty-six (36) months~~
24 ~~pursuant to KRS 304.17A-132.~~

25 ~~(15) Any policy provided to state employees or their dependents pursuant to this section~~
26 ~~shall provide coverage for the diagnosis and treatment of autism spectrum disorders~~
27 ~~consistent with KRS 304.17A-142.~~

1 ~~(16) Any policy provided to state employees or their dependents pursuant to this section~~
2 ~~shall provide coverage for obtaining amino acid based elemental formula pursuant~~
3 ~~to KRS 304.17A-258.~~

4 ~~(17)~~ If a state employee's residence and place of employment are in the same county, and
5 if the hospital located within that county does not offer surgical services, intensive
6 care services, obstetrical services, level II neonatal services, diagnostic cardiac
7 catheterization services, and magnetic resonance imaging services, the employee
8 may select a plan available in a contiguous county that does provide those services,
9 and the state contribution for the plan shall be the amount available in the county
10 where the plan selected is located.

11 ~~(15)~~~~(18)~~ If a state employee's residence and place of employment are each located in
12 counties in which the hospitals do not offer surgical services, intensive care
13 services, obstetrical services, level II neonatal services, diagnostic cardiac
14 catheterization services, and magnetic resonance imaging services, the employee
15 may select a plan available in a county contiguous to the county of residence that
16 does provide those services, and the state contribution for the plan shall be the
17 amount available in the county where the plan selected is located.

18 ~~(16)~~~~(19)~~ The Personnel Cabinet is encouraged to study whether it is fair and reasonable
19 and in the best interests of the state group to allow any carrier bidding to offer
20 health care coverage under this section to submit bids that may vary county by
21 county or by larger geographic areas.

22 ~~(17)~~~~(20)~~ Notwithstanding any other provision of this section, the bid for proposals for
23 health insurance coverage for calendar year 2004 shall include a bid scenario that
24 reflects the statewide rating structure provided in calendar year 2003 and a bid
25 scenario that allows for a regional rating structure that allows carriers to submit bids
26 that may vary by region for a given product offering as described in this subsection:

27 (a) The regional rating bid scenario shall not include a request for bid on a

1 statewide option;

2 (b) The Personnel Cabinet shall divide the state into geographical regions which
3 shall be the same as the partnership regions designated by the Department for
4 Medicaid Services for purposes of the Kentucky Health Care Partnership
5 Program established pursuant to 907 KAR 1:705;

6 (c) The request for proposal shall require a carrier's bid to include every county
7 within the region or regions for which the bid is submitted and include but not
8 be restricted to a preferred provider organization (PPO) option;

9 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
10 carrier all of the counties included in its bid within the region. If the Personnel
11 Cabinet deems the bids submitted in accordance with this subsection to be in
12 the best interests of state employees in a region, the cabinet may award the
13 contract for that region to no more than two (2) carriers; and

14 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
15 other requirements or criteria in the request for proposal.

16 ~~(18)~~~~(21)~~ Any fully insured health benefit plan or self-insured plan issued or renewed on
17 or after the effective date of this Act~~[July 12, 2006,]~~ and provided to public
18 employees pursuant to this section shall:

19 (a) Provide coverage meeting the requirements of:

20 1. KRS 304.17A-132;

21 2. KRS 304.17A-142; and

22 3. KRS 304.17A-258;

23 (b) If the plan~~[which]~~ provides coverage for services rendered by a physician or
24 osteopath duly licensed under KRS Chapter 311 that are within the scope of
25 practice of an optometrist duly licensed under the provisions of KRS Chapter
26 320, ~~shall~~ provide the same payment of coverage to optometrists as allowed
27 for those services rendered by physicians or osteopaths; and

1 (c) Comply with the provisions of:

2 1. KRS 304.17A-270 and 304.17A-525; and

3 2. KRS 304.17A-600 to 304.17A-633 pertaining to utilization review,
4 KRS 205.593 and 304.17A-700 to 304.17A-730 pertaining to payment
5 of claims, KRS 304.14-135 pertaining to uniform health insurance
6 claim forms, KRS 304.17A-580 pertaining to emergency medical care,
7 KRS 304.99-123, and any administrative regulations promulgated
8 pursuant to these sections.

9 ~~[(22) Any fully insured health benefit plan or self-insured plan issued or renewed on or~~
10 ~~after July 12, 2006, to public employees pursuant to this section shall comply with~~
11 ~~the provisions of KRS 304.17A-270 and 304.17A-525.~~

12 ~~(23) Any full insured health benefit plan or self-insured plan issued or renewed on or~~
13 ~~after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to~~
14 ~~304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to~~
15 ~~304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to~~
16 ~~uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641~~
17 ~~pertaining to emergency medical care, KRS 304.99-123, and any administrative~~
18 ~~regulations promulgated thereunder.]~~

19 ➔Section 8. KRS 304.17B-001 is amended to read as follows:

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

- 21 (1) "Administrator" is defined in KRS 304.9-051(1);
- 22 (2) "Agent" is defined in KRS 304.9-020;
- 23 (3) "Assessment process" means the process of assessing and allocating guaranteed
- 24 acceptance program losses or Kentucky Access funding as provided for in KRS
- 25 304.17B-021;
- 26 (4) "Authority" means the Kentucky Health Care Improvement Authority;
- 27 (5) "Case management" means a process for identifying an enrollee with specific health

- 1 care needs and interacting with the enrollee and their respective health care
2 providers in order to facilitate the development and implementation of a plan that
3 efficiently uses health care resources to achieve optimum health outcome;
- 4 (6) "Commissioner" is defined in KRS 304.1-050(1);
- 5 (7) "Department" is defined in KRS 304.1-050(2);
- 6 (8) "Earned premium" means the portion of premium paid by an insured that has been
7 allocated to the insurer's loss experience, expenses, and profit year to date;
- 8 (9) "Enrollee" means a person who is enrolled in a health benefit plan offered under
9 Kentucky Access;
- 10 (10) "Eligible individual" is defined in KRS 304.17A-005(11);
- 11 (11) "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed
12 Acceptance Program established and operated under KRS 304.17A-400 to
13 304.17A-480;
- 14 (12) "Guaranteed acceptance program participating insurer" means an insurer that
15 offered health benefit plans through December 31, 2000, in the individual market to
16 guaranteed acceptance program qualified individuals;
- 17 (13) "Health benefit plan" is defined in KRS 304.17A-005(22);
- 18 (14) "High-cost condition" means acquired immune deficiency syndrome (AIDS), angina
19 pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency,
20 coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's
21 disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor
22 or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis,
23 myotonia, open-heart surgery, Parkinson's disease, polycystic kidney, psychotic
24 disorders, quadriplegia, stroke, syringomyelia, Wilson's disease, chronic renal
25 failure, malignant neoplasm of the trachea, malignant neoplasm of the bronchus,
26 malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation
27 period for a newborn child, and low birth weight of a newborn child;

- 1 (15) "Incurred losses" means for Kentucky Access the excess of claims paid over
2 premiums received;
- 3 (16) "Insurer" is defined in KRS 304.17A-005(27);
- 4 (17) "Kentucky Access" means the program established in accordance with KRS
5 304.17B-001 to 304.17B-031;
- 6 (18) "Kentucky Access Fund" means the fund established in KRS 304.17B-021;
- 7 (19) "Kentucky Health Care Improvement Authority" means the board established to
8 administer the program initiatives listed in KRS 304.17B-003(5);
- 9 (20) "Kentucky Health Care Improvement Fund" means the fund established for receipt
10 of the Kentucky tobacco master settlement moneys for program initiatives listed in
11 KRS 304.17B-003(5);
- 12 (21) "MARS" means the Management Administrative Reporting System administered by
13 the Commonwealth;
- 14 (22) "Medicaid" means coverage in accordance with Title XIX of the Social Security
15 Act, 42 U.S.C. secs. 1396 et seq., as amended;
- 16 (23) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social
17 Security Act, 42 U.S.C. secs. 1395 et seq., as amended;
- 18 (24) "Pre-existing condition exclusion" is defined in KRS 304.17A-220(6);
- 19 (25) "Standard health benefit plan" means a health benefit plan that meets the
20 requirements of KRS 304.17A-250;
- 21 (26) "Stop-loss carrier" means any person providing stop-loss health insurance coverage;
- 22 (27) "Supporting insurer" means all insurers, stop-loss carriers, and self-insured
23 employer-controlled or bona fide associations; and
- 24 (28) "Utilization management" is defined in KRS 304.17A-500~~{(12)}~~.

25 ➔Section 9. The following KRS sections are repealed:

26 304.17A-640 Definitions for KRS 304.17A-640 et seq.

27 304.17A-641 Treatment of a stabilized covered person with an emergency medical

1 condition in a nonparticipating hospital's emergency room.

2 304.17A-649 Administrative regulations for the implementation of KRS 304.17A-640 et

3 seq.

4 ➔Section 10. This Act takes effect on January 1, 2019.