

1 AN ACT relating to prior authorization.

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

3 ➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304
4 IS CREATED TO READ AS FOLLOWS:

5 *(1) On or before the effective date of this Act, an insurer offering a health benefit*
6 *plan shall develop, coordinate, or adopt a process for electronically requesting*
7 *and transmitting prior authorization for a drug by providers. The process shall be*
8 *accessible by providers and meet the most recent National Council for*
9 *Prescription Drug Programs SCRIPT standards for electronic prior*
10 *authorization transactions adopted by the United States Department of Health*
11 *and Human Services. Facsimile, proprietary payer portals, and electronic forms*
12 *shall not be considered electronic transmission.*

13 *(2) Unless otherwise provided in subsection (3) of this section or prohibited by state*
14 *or federal law, if a provider receives a prior authorization for a drug prescribed to*
15 *a covered person with a condition that requires ongoing medication therapy, and*
16 *the provider continues to prescribe the drug, and the drug is used for a condition*
17 *that is within the scope of use approved by the United States Food and Drug*
18 *Administration or has been proven to be a safe and effective form of treatment*
19 *for the patient's specific underlying condition based on clinical practice*
20 *guidelines that are developed from peer-reviewed publications, the prior*
21 *authorization received shall:*

22 *(a) Be valid for the lesser of:*

23 *1. One (1) year from the date the provider receives the prior*
24 *authorization; or*

25 *2. Until the last day of coverage under the covered person's health*
26 *benefit plan during a single plan year; and*

27 *(b) Cover any change in dosage prescribed by the provider during the period of*

1 authorization.

2 (3) (a) Except as provided in paragraph (b) of this subsection, the provisions of
 3 subsection (2) of this section shall not apply to:

4 1. Medications that are prescribed for a non-maintenance condition;

5 2. Medications that have a typical treatment period of less than twelve
 6 (12) months;

7 3. Medications where there is medical or scientific evidence that do not
 8 support a twelve (12) month approval; or

9 4. Medications that are opioid analgesics or benzodiazepines.

10 (b) Paragraph (a) of this subsection shall not apply to any medication that is
 11 prescribed to a patient in a community-based palliative care program.

12 ➔Section 2. KRS 205.522 is amended to read as follows:

13 The Department for Medicaid Services and any managed care organization contracted
 14 to provide~~[a managed care organization that provides]~~ Medicaid benefits pursuant to this
 15 chapter shall comply with the provisions of KRS 304.17A-235, 304.17A-515, ~~[and]~~
 16 304.17A-740 to 304.17A-743, Sections 1, 6, 7, 8, and 9 of this Act, as applicable.

17 ➔Section 3. KRS 217.211 is amended to read as follows:

18 (1) Electronic prescribing of a drug or device under this chapter shall not interfere with
 19 a patient's freedom to select a pharmacy.

20 (2) Electronic prescribing software used by a practitioner to prescribe a drug or device
 21 under this chapter may include clinical messaging and messages in pop-up windows
 22 directed to the practitioner regarding a particular drug or device that supports the
 23 practitioner's clinical decision making.

24 (3) Drug information contained in electronic prescribing software to prescribe a drug or
 25 device under this chapter shall be consistent with Food and Drug Administration-
 26 approved information regarding a particular drug or device.

27 (4) (a) Electronic prescribing software used by a practitioner to prescribe a drug or

1 device under this chapter may show information regarding a payor's
 2 formulary, copayments, or benefit plan, provided that nothing in the software
 3 is designed to preclude a practitioner from selecting any particular pharmacy
 4 or drug or device.

5 **(b) If electronic prescribing software does show information regarding a**
 6 **payor's formulary, payments, or benefit plan under paragraph (a) of this**
 7 **subsection, the information shall be updated at least quarterly to ensure its**
 8 **accuracy.**

9 (5) ~~[Within twenty four (24) months of the National Council for Prescription Drug~~
 10 ~~Programs developing and making available national standards for electronic prior~~
 11 ~~authorization,]Each governmental unit of the Commonwealth promulgating~~
 12 administrative regulations relating to electronic prescribing **shall include in the**
 13 **regulations**~~[shall consider such electronic prescribing and]~~ electronic prior
 14 authorization standards **meeting the requirements of Section 1 of this Act** in its
 15 implementation of health information technology improvements as required by the
 16 Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the
 17 Health Information Technology for Economic and Clinical Health Act, enacted as
 18 part of the American Recovery and Reinvestment Act of 2009.

19 ➔Section 4. KRS 218A.171 is amended to read as follows:

20 (1) Electronic prescribing of a controlled substance under this chapter shall not interfere
 21 with a patient's freedom to select a pharmacy.

22 (2) Electronic prescribing software used by a practitioner to prescribe a controlled
 23 substance under this chapter may include clinical messaging and messages in pop-
 24 up windows directed to the practitioner regarding a particular controlled substance
 25 that supports the practitioner's clinical decision making.

26 (3) Drug information contained in electronic prescribing software to prescribe a
 27 controlled substance under this chapter shall be consistent with Food and Drug

1 Administration-approved information regarding a particular controlled substance.

2 (4) (a) Electronic prescribing software used by a practitioner to prescribe a controlled
 3 substance under this chapter may show information regarding a payor's
 4 formulary, copayments, or benefit plan, provided that nothing in the software
 5 is designed to preclude a practitioner from selecting any particular pharmacy
 6 or controlled substance.

7 **(b) If electronic prescribing software does show information regarding a**
 8 **payor's formulary, payments, or benefit plan under paragraph (a) of this**
 9 **subsection, the information shall be updated at least quarterly to ensure its**
 10 **accuracy.**

11 (5) ~~[Within twenty four (24) months of the National Council for Prescription Drug~~
 12 ~~Programs developing and making available national standards for electronic prior~~
 13 ~~authorization,]Each governmental unit of the Commonwealth promulgating~~
 14 administrative regulations relating to electronic prescribing **shall include in the**
 15 **regulations**~~[shall consider such electronic prescribing and]~~ electronic prior
 16 authorization standards **meeting the requirements of Section 1 of this Act** in its
 17 implementation of health information technology improvements as required by the
 18 Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the
 19 Health Information Technology for Economic and Clinical Health Act, enacted as
 20 part of the American Recovery and Reinvestment Act of 2009.

21 ➔Section 5. KRS 304.17A-005 (Effective July 1, 2019) is amended to read as
 22 follows:

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

24 (1) "Association" means an entity, other than an employer-organized association, that
 25 has been organized and is maintained in good faith for purposes other than that of
 26 obtaining insurance for its members and that has a constitution and bylaws;

27 (2) "At the time of enrollment" means:

- 1 (a) At the time of application for an individual, an association that actively
2 markets to individual members, and an employer-organized association that
3 actively markets to individual members; and
- 4 (b) During the time of open enrollment or during an insured's initial or special
5 enrollment periods for group health insurance;
- 6 (3) "Base premium rate" means, for each class of business as to a rating period, the
7 lowest premium rate charged or that could have been charged under the rating
8 system for that class of business by the insurer to the individual or small group, or
9 employer as defined in KRS 304.17A-0954, with similar case characteristics for
10 health benefit plans with the same or similar coverage;
- 11 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,
12 or employer-organized association that limits coverage to physician, pharmacy,
13 home health, preventive, emergency, and inpatient and outpatient hospital services
14 in accordance with the requirements of this subtitle. If vision or eye services are
15 offered, these services may be provided by an ophthalmologist or optometrist.
16 Chiropractic benefits may be offered by providers licensed pursuant to KRS
17 Chapter 312;
- 18 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
19 91(d)(3);
- 20 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
- 21 (7) "COBRA" means any of the following:
- 22 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
23 vaccines;
- 24 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
25 et seq. other than sec. 1169); or
- 26 (c) 42 U.S.C. sec. 300bb;
- 27 (8) ~~{(a)}~~"Creditable coverage";

- 1 (a) Means, with respect to an individual, coverage of the individual under any of
 2 the following:
- 3 1. A group health plan;
 - 4 2. Health insurance coverage;
 - 5 3. Part A or Part B of Title XVIII of the Social Security Act;
 - 6 4. Title XIX of the Social Security Act, other than coverage consisting
 7 solely of benefits under section 1928;
 - 8 5. Chapter 55 of Title 10, United States Code, including medical and dental
 9 care for members and certain former members of the uniformed services,
 10 and for their dependents; for purposes of Chapter 55 of Title 10, United
 11 States Code, "uniformed services" means the Armed Forces and the
 12 Commissioned Corps of the National Oceanic and Atmospheric
 13 Administration and of the Public Health Service;
 - 14 6. A medical care program of the Indian Health Service or of a tribal
 15 organization;
 - 16 7. A state health benefits risk pool;
 - 17 8. A health plan offered under Chapter 89 of Title 5, United States Code,
 18 such as the Federal Employees Health Benefit Program;
 - 19 9. A public health plan as established or maintained by a state, the United
 20 States government, a foreign country, or any political subdivision of a
 21 state, the United States government, or a foreign country that provides
 22 health coverage to individuals who are enrolled in the plan;
 - 23 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
 24 U.S.C. sec. 2504(e)); or
 - 25 11. Title XXI of the Social Security Act, such as the State Children's Health
 26 Insurance Program; and ~~[-]~~
- 27 (b) ~~[-]~~ Does not include coverage consisting solely of coverage of

1 excepted benefits as defined in ~~subsection (14) of~~ this section;

2 (9) "Dependent" means any individual who is or may become eligible for coverage
3 under the terms of an individual or group health benefit plan because of a
4 relationship to a participant;

5 (10) "Employee benefit plan" means an employee welfare benefit plan or an employee
6 pension benefit plan or a plan which is both an employee welfare benefit plan and
7 an employee pension benefit plan as defined by ERISA;

8 (11) "Eligible individual" means an individual:

9 (a) For whom, as of the date on which the individual seeks coverage, the
10 aggregate of the periods of creditable coverage is eighteen (18) or more
11 months and whose most recent prior creditable coverage was under a group
12 health plan, governmental plan, or church plan. A period of creditable
13 coverage under this paragraph shall not be counted if, after that period, there
14 was a sixty-three (63) day period of time, excluding any waiting or affiliation
15 period, during all of which the individual was not covered under any
16 creditable coverage;

17 (b) Who is not eligible for coverage under a group health plan, Part A or Part B of
18 Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a
19 state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et
20 seq.) and does not have other health insurance coverage;

21 (c) With respect to whom the most recent coverage within the coverage period
22 described in paragraph (a) of this subsection was not terminated based on a
23 factor described in KRS 304.17A-240(2)(a), (b), and (c);

24 (d) If the individual had been offered the option of continuation coverage under a
25 COBRA continuation provision or under KRS 304.18-110, who elected the
26 coverage; and

27 (e) Who, if the individual elected the continuation coverage, has exhausted the

1 continuation coverage under the provision or program;

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

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

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

9 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-
10 91(d)(3), whose members consist principally of employers, and for which the
11 entity's health insurance decisions are made by a board or committee, the
12 majority of which are representatives of employer members of the entity who
13 obtain group health insurance coverage through the entity or through a trust or
14 other mechanism established by the entity, and whose health insurance
15 decisions are reflected in written minutes or other written documentation.

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

22 (13) "Employer-organized association health insurance plan" means any health insurance
23 plan, policy, or contract issued to an employer-organized association, or to a trust
24 established by one (1) or more employer-organized associations, or providing
25 coverage solely for the employees, retired employees, directors and their spouses
26 and dependents of the members of one (1) or more employer-organized
27 associations;

- 1 (14) "Excepted benefits" means benefits under one (1) or more, or any combination ~~of~~
2 ~~thereof,~~ of the following:
- 3 (a) Coverage only for accident, including accidental death and dismemberment,
4 or disability income insurance, or any combination thereof;
 - 5 (b) Coverage issued as a supplement to liability insurance;
 - 6 (c) Liability insurance, including general liability insurance and automobile
7 liability insurance;
 - 8 (d) Workers' compensation or similar insurance;
 - 9 (e) Automobile medical payment insurance;
 - 10 (f) Credit-only insurance;
 - 11 (g) Coverage for on-site medical clinics;
 - 12 (h) Other similar insurance coverage, specified in administrative regulations,
13 under which benefits for medical care are secondary or incidental to other
14 insurance benefits;
 - 15 (i) Limited scope dental or vision benefits;
 - 16 (j) Benefits for long-term care, nursing home care, home health care, community-
17 based care, or any combination thereof;
 - 18 (k) Such other similar, limited benefits as are specified in administrative
19 regulations;
 - 20 (l) Coverage only for a specified disease or illness;
 - 21 (m) Hospital indemnity or other fixed indemnity insurance;
 - 22 (n) Benefits offered as Medicare supplemental health insurance, as defined under
23 section 1882(g)(1) of the Social Security Act;
 - 24 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
25 United States Code;
 - 26 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
27 supplemental to coverage under a group health plan; and

- 1 (q) Health flexible spending arrangements;
- 2 (15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
3 1002(32);
- 4 (16) "Group health plan" means a plan, including a self-insured plan, of or contributed to
5 by an employer, including a self-employed person, or employee organization, to
6 provide health care directly or otherwise to the employees, former employees, the
7 employer, or others associated or formerly associated with the employer in a
8 business relationship, or their families;
- 9 (17) "Guaranteed acceptance program participating insurer" means an insurer that is
10 required to or has agreed to offer health benefit plans in the individual market to
11 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
12 304.17A-480;
- 13 (18) "Guaranteed acceptance program plan" means a health benefit plan in the individual
14 market issued by an insurer that provides health benefits to a guaranteed acceptance
15 program qualified individual and is eligible for assessment and refunds under the
16 guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
- 17 (19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance
18 Program established and operated under KRS 304.17A-400 to 304.17A-480;
- 19 (20) "Guaranteed acceptance program qualified individual" means an individual who, on
20 or before December 31, 2000:
- 21 (a) Is not an eligible individual;
- 22 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
23 spouse or a dependent of an individual who:
- 24 1. Waived coverage under KRS 304.17A-210(2); or
25 2. Did not elect family coverage that was available through the association
26 or group market;
- 27 (c) Within the previous three (3) years has been diagnosed with or treated for a

1 high-cost condition or has had benefits paid under a health benefit plan for a
2 high-cost condition, or is a high risk individual as defined by the underwriting
3 criteria applied by an insurer under the alternative underwriting mechanism
4 established in KRS 304.17A-430(3);

5 (d) Has been a resident of Kentucky for at least twelve (12) months immediately
6 preceding the effective date of the policy; and

7 (e) Has not had his or her most recent coverage under any health benefit plan
8 terminated or nonrenewed because of any of the following:

9 1. The individual failed to pay premiums or contributions in accordance
10 with the terms of the plan or the insurer had not received timely
11 premium payments;

12 2. The individual performed an act or practice that constitutes fraud or
13 made an intentional misrepresentation of material fact under the terms of
14 the coverage; or

15 3. The individual engaged in intentional and abusive noncompliance with
16 health benefit plan provisions;

17 (21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or
18 before December 31, 2000, that is not a guaranteed acceptance plan participating
19 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
20 guaranteed acceptance plan supporting insurer shall not include an employer-
21 sponsored self-insured health benefit plan exempted by ERISA;

22 (22) "Health benefit plan":

23 (a) Means any:

24 1. Hospital or medical expense policy or certificate;

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

27 3. Provider sponsored integrated health delivery network;

- 1 4. ~~{A}~~ Self-insured plan or a plan provided by a multiple employer welfare
 2 arrangement, to the extent permitted by ERISA;
 3 5. Health maintenance organization contract, except contracts to provide
 4 Medicaid benefits under KRS Chapter 205; or
 5 6. ~~{Any}~~ Health benefit plan that affects the rights of a Kentucky insured
 6 and bears a reasonable relation to Kentucky, whether delivered or issued
 7 for delivery in Kentucky; ~~{,}~~ and

8 **(b)** Does not include:

- 9 1. Policies covering only accident, credit, dental, disability income, fixed
 10 indemnity medical expense reimbursement ~~{policy}~~, long-term care,
 11 Medicare supplement, specified disease, or vision care; ~~{,}~~
 12 2. Coverage issued as a supplement to liability insurance; ~~{,}~~
 13 3. Insurance arising out of a workers' compensation or similar law; ~~{,}~~
 14 4. Automobile medical-payment insurance; ~~{,}~~
 15 5. Insurance under which benefits are payable with or without regard to
 16 fault and that is statutorily required to be contained in any liability
 17 insurance policy or equivalent self-insurance; ~~{,}~~
 18 6. Short-term coverage; ~~{,}~~
 19 7. Student health insurance offered by a Kentucky-licensed insurer under
 20 written contract with a university or college whose students it proposes
 21 to insure; ~~{,}~~
 22 8. Medical expense reimbursement policies specifically designed to fill
 23 gaps in primary coverage, coinsurance, or deductibles and provided
 24 under a separate policy, certificate, or contract; ~~{, or}~~
 25 9. Coverage supplemental to the coverage provided under Chapter 55 of
 26 Title 10, United States Code; ~~{, or}~~
 27 10. Limited health service benefit plans; ~~{, or}~~

1 **11.** Direct primary care agreements established under KRS 311.6201,
2 311.6202, 314.198, and 314.199; **or**

3 **12. Coverage provided under KRS Chapter 205;**

4 (23) "Health care provider" or "provider" means any ~~facility or service required to be~~
5 ~~licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS~~
6 ~~Chapter 315, or home medical equipment and services provider as defined pursuant~~
7 ~~to KRS 309.402, and any of the following independent practicing practitioners]:~~

8 (a) **Advanced practice registered nurse licensed under KRS Chapter**
9 **314**~~[Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311];~~

10 (b) **Chiropractor**~~[Chiropractors]~~ licensed under KRS Chapter 312;

11 (c) **Dentist**~~[Dentists]~~ licensed under KRS Chapter 313;

12 (d) **Facility or service required to be licensed under KRS Chapter**
13 **216B**~~[Optometrists licensed under KRS Chapter 320];~~

14 (e) **Home medical equipment and services provider licensed under KRS**
15 **Chapter 309**~~[Physician assistants regulated under KRS Chapter 311];~~

16 (f) **Optometrist licensed under KRS Chapter 320;**~~[Advanced practice registered~~
17 ~~nurses licensed under KRS Chapter 314; and]~~

18 (g) **Pharmacist licensed under KRS Chapter 315;**

19 **(h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;**

20 **(i) Physician assistant regulated under KRS Chapter 311; and**

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

23 **(24) (a) "Health care service" means health care procedures, treatments, or services**
24 **rendered by a provider within the scope of practice for which the provider is**
25 **licensed.**

26 **(b) Health care service includes the provision of prescription drugs, as defined**
27 **in KRS 315.010, and home medical equipment, as defined in KRS 309.402;**

1 **(25) "Health facility" or "facility" has the same meaning as in KRS 216B.015;**

2 ~~(26)~~~~(24)~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
3 Program, means a covered condition in an individual policy as listed in
4 paragraph (c) of this subsection or as added by the commissioner in
5 accordance with KRS 304.17A-280, but only to the extent that the condition
6 exceeds the numerical score or rating established pursuant to uniform
7 underwriting standards prescribed by the commissioner under paragraph (b) of
8 this subsection that account for the severity of the condition and the cost
9 associated with treating that condition.

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

- 13 1. Codes in the most recent version of the "International Classification of
14 Diseases" that correspond to the medical conditions in paragraph (c) of
15 this subsection and the costs for administering treatment for the
16 conditions represented by those codes; and
- 17 2. The most recent version of the questionnaire incorporated in a national
18 underwriting guide generally accepted in the insurance industry as
19 designated by the commissioner, the scoring scale for which shall be
20 established by the commissioner.

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

1 stroke, syringomyelia, ~~and~~ Wilson's disease, and amyotrophic lateral
2 sclerosis;

3 (27)~~(25)~~ "Index rate" means, for each class of business as to a rating period, the
4 arithmetic average of the applicable base premium rate and the corresponding
5 highest premium rate;

6 (28)~~(26)~~ "Individual market" means the market for the health insurance coverage
7 offered to individuals other than in connection with a group health plan. The
8 individual market includes an association plan that is not employer related, issued to
9 individuals on an individually underwritten basis, other than an employer-organized
10 association or a bona fide association, that has been organized and is maintained in
11 good faith for purposes other than obtaining insurance for its members and that has
12 a constitution and bylaws;

13 (29)~~(27)~~ "Insurer" means any insurance company; health maintenance organization;
14 self-insurer or multiple employer welfare arrangement not exempt from state
15 regulation by ERISA; provider-sponsored integrated health delivery network; self-
16 insured employer-organized association, or nonprofit hospital, medical-surgical,
17 dental, or health service corporation authorized to transact health insurance business
18 in Kentucky;

19 (30)~~(28)~~ "Insurer-controlled" means that the commissioner has found, in an
20 administrative hearing called specifically for that purpose, that an insurer has or had
21 a substantial involvement in the organization or day-to-day operation of the entity
22 for the principal purpose of creating a device, arrangement, or scheme by which the
23 insurer segments employer groups according to their actual or anticipated health
24 status or actual or projected health insurance premiums;

25 (31)~~(29)~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001~~(17)~~;

26 (32)~~(30)~~ "Large group" means:

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

- 1 (b) An affiliated group with fifty-one (51) or more eligible members; or
 2 (c) An employer-organized association that is a bona fide association as defined
 3 in ~~subsection (5) of~~ this section;

4 **(33)**~~(31)~~ "Managed care" means systems or techniques generally used by third-party
 5 payors or their agents to affect access to and control payment for health care
 6 services and that integrate the financing and delivery of appropriate health care
 7 services to covered persons by arrangements with participating providers who are
 8 selected to participate on the basis of explicit standards for furnishing a
 9 comprehensive set of health care services and financial incentives for covered
 10 persons using the participating providers and procedures provided for in the plan;

11 **(34)**~~(32)~~ "Market segment" means the portion of the market covering one (1) of the
 12 following:

- 13 (a) Individual;
 14 (b) Small group;
 15 (c) Large group; or
 16 (d) Association;

17 **(35)** "Medically necessary health care services" means health care services that a
 18 provider would render to a patient for the purpose of preventing, diagnosing, or
 19 treating an illness, injury, disease, or its symptoms in a manner that is:

- 20 (a) In accordance with generally accepted standards of medical practice; and
 21 (b) Clinically appropriate in terms of type, frequency, extent, and duration;

22 **(36)**~~(33)~~ "Participant" means any employee or former employee of an employer, or any
 23 member or former member of an employee organization, who is or may become
 24 eligible to receive a benefit of any type from an employee benefit plan which covers
 25 employees of the employer or members of the organization, or whose beneficiaries
 26 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

27 **(37)**~~(34)~~ "Preventive services" means medical services for the early detection of disease

1 that are associated with substantial reduction in morbidity and mortality;

2 ~~(38)~~~~(35)~~ "Provider network" means an affiliated group of varied health care providers
3 that is established to provide a continuum of health care services to individuals;

4 ~~(39)~~~~(36)~~ "Provider-sponsored integrated health delivery network" means any provider-
5 sponsored integrated health delivery network created and qualified under KRS
6 304.17A-300 and KRS 304.17A-310;

7 ~~(40)~~~~(37)~~ "Purchaser" means an individual, organization, employer, association, or the
8 Commonwealth that makes health benefit purchasing decisions on behalf of a group
9 of individuals;

10 ~~(41)~~~~(38)~~ "Rating period" means the calendar period for which premium rates are in
11 effect. A rating period shall not be required to be a calendar year;

12 ~~(42)~~~~(39)~~ "Restricted provider network" means a health benefit plan that conditions the
13 payment of benefits, in whole or in part, on the use of the providers that have
14 entered into a contractual arrangement with the insurer to provide health care
15 services to covered individuals;

16 ~~(43)~~~~(40)~~ "Self-insured plan" means a group health insurance plan in which the
17 sponsoring organization assumes the financial risk of paying for covered services
18 provided to its enrollees;

19 ~~(44)~~~~(41)~~ "Small employer" means, in connection with a group health plan with respect
20 to a calendar year and a plan year, an employer who employed an average of at least
21 two (2) but not more than fifty (50) employees on business days during the
22 preceding calendar year and who employs at least two (2) employees on the first day
23 of the plan year;

24 ~~(45)~~~~(42)~~ "Small group" means:

25 (a) A small employer with two (2) to fifty (50) employees; or

26 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

27 ~~(46)~~~~(43)~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

1 ~~(47)~~~~[(44)]~~ "Telehealth":

2 (a) Means the delivery of health care-related services by a health care provider
3 who is licensed in Kentucky to a patient or client through a face-to-face
4 encounter with access to real-time interactive audio and video technology or
5 store and forward services that are provided via asynchronous technologies as
6 the standard practice of care where images are sent to a specialist for
7 evaluation. The requirement for a face-to-face encounter shall be satisfied
8 with the use of asynchronous telecommunications technologies in which the
9 health care provider has access to the patient's or client's medical history prior
10 to the telehealth encounter;

11 (b) Shall not include the delivery of services through electronic mail, text chat,
12 facsimile, or standard audio-only telephone call; and

13 (c) Shall be delivered over a secure communications connection that complies
14 with the federal Health Insurance Portability and Accountability Act of 1996,
15 42 U.S.C. secs. 1320d to 1320d-9.

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

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

21 (2) An insurer offering health benefit plans shall cover emergency medical conditions
22 and shall pay for emergency department screening and stabilization services both in-
23 network and out-of-network without prior authorization for conditions that
24 reasonably appear to a prudent layperson to constitute an emergency medical
25 condition based on the patient's presenting symptoms and condition. An insurer
26 shall be prohibited from denying the emergency department~~from~~ services and
27 altering the level of coverage or cost-sharing requirements for any condition or

1 conditions that constitute an emergency medical condition as defined in KRS
2 304.17A-500.

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

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

9 ➔Section 7. KRS 304.17A-600 is amended to read as follows:

10 As used in KRS 304.17A-600 to 304.17A-633:

11 (1) (a) "Adverse determination" means a determination by an insurer or its designee
12 that the health care services furnished or proposed to be furnished to a covered
13 person are:

14 1. Not medically necessary, as determined by the insurer, or its designee or
15 experimental or investigational, as determined by the insurer, or its
16 designee; and

17 2. Benefit coverage is therefore denied, reduced, or terminated.

18 (b) "Adverse determination" does not mean a determination by an insurer or its
19 designee that the health care services furnished or proposed to be furnished to
20 a covered person are specifically limited or excluded in the covered person's
21 health benefit plan;

22 (2) "Authorized person" means a parent, guardian, or other person authorized to act on
23 behalf of a covered person with respect to health care decisions;

24 (3) "Concurrent review" means utilization review conducted during a covered person's
25 course of treatment or hospital stay;

26 (4) "Covered person" means a person covered under a health benefit plan;

27 (5) "External review" means a review that is conducted by an independent review entity

1 which meets specified criteria as established in KRS 304.17A-623, 304.17A-625,
2 and 304.17A-627;

3 (6) "Health benefit plan" has the same meaning as in Section 5 of this Act, except
4 that~~means the document evidencing and setting forth the terms and conditions of~~
5 ~~coverage of any hospital or medical expense policy or certificate; nonprofit hospital,~~
6 ~~medical surgical, and health service corporation contract or certificate; provider~~
7 ~~sponsored integrated health delivery network policy or certificate; a self insured~~
8 ~~policy or certificate or a policy or certificate provided by a multiple employer~~
9 ~~welfare arrangement, to the extent permitted by ERISA; health maintenance~~
10 ~~organization contract; or any health benefit plan that affects the rights of a Kentucky~~
11 ~~insured and bears a reasonable relation to Kentucky, whether delivered or issued for~~
12 ~~delivery in Kentucky, and does not include policies covering only accident, credit,~~
13 ~~dental, disability income, fixed indemnity medical expense reimbursement policy,~~
14 ~~long term care, Medicare supplement, specified disease, vision care, coverage~~
15 ~~issued as a supplement to liability insurance, insurance arising out of a workers'~~
16 ~~compensation or similar law, automobile medical payment insurance, insurance~~
17 ~~under which benefits are payable with or without regard to fault and that is~~
18 ~~statutorily required to be contained in any liability insurance policy or equivalent~~
19 ~~self insurance, student health insurance offered by a Kentucky licensed insurer~~
20 ~~under written contract with a university or college whose students it proposes to~~
21 ~~insure, medical expense reimbursement policies specifically designed to fill gaps in~~
22 ~~primary coverage, coinsurance, or deductibles and provided under a separate policy,~~
23 ~~certificate, or contract, or coverage supplemental to the coverage provided under~~
24 ~~Chapter 55 of Title 10, United States Code; or limited health service benefit plans;~~
25 ~~and~~ for purposes of KRS 304.17A-600 to 304.17A-633 the term includes short-
26 term coverage policies;

27 (7) "Independent review entity" means an individual or organization certified by the

1 department to perform external reviews under KRS 304.17A-623, 304.17A-625,
2 and 304.17A-627;

3 (8) "Insurer" means any of the following entities authorized to issue health benefit plans
4 as defined in subsection (6) of this section: an insurance company, health
5 maintenance organization; self-insurer or multiple employer welfare arrangement
6 not exempt from state regulation by ERISA; provider-sponsored integrated health
7 delivery network; self-insured employer-organized association; nonprofit hospital,
8 medical-surgical, or health service corporation; or any other entity authorized to
9 transact health insurance business in Kentucky;

10 (9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-
11 617, established and maintained by the insurer, its designee, or agent whereby the
12 covered person, an authorized person, or a provider may contest an adverse
13 determination rendered by the insurer, its designee, or private review agent;

14 (10) "Nationally recognized accreditation organization" means a private nonprofit entity
15 that sets national utilization review and internal appeal standards and conducts
16 review of insurers, agents, or independent review entities for the purpose of
17 accreditation or certification. Nationally recognized accreditation organizations
18 shall include the Accreditation Association for Ambulatory Health Care (AAAHC),
19 the National Committee for Quality Assurance (NCQA), the American
20 Accreditation Health Care Commission (URAC), the Joint Commission, or any
21 other organization identified by the department;

22 (11) "Private review agent" or "agent" means a person or entity performing utilization
23 review that is either affiliated with, under contract with, or acting on behalf of any
24 insurer or other person providing or administering health benefits to citizens of this
25 Commonwealth. "Private review agent" or "agent" does not include an independent
26 review entity which performs external review of adverse determinations;

27 (12) "Prospective review" means a utilization review that is conducted prior to the

1 provision of health care services.[a hospital admission or a course of treatment]
 2 "Prospective review" also includes any insurer's or agent's requirement that a
 3 covered person or provider notify the insurer or agent prior to providing a health
 4 care service, including but not limited to prior authorization, step therapy,
 5 preadmission review, pretreatment review, utilization, and case management;

6 (13) ~~["Provider" shall have the same meaning as set forth in KRS 304.17A-005;~~

7 ~~(14)~~ "Qualified personnel" means licensed physician, registered nurse, licensed practical
 8 nurse, medical records technician, or other licensed medical personnel who through
 9 training and experience shall render consistent decisions based on the review
 10 criteria;

11 ~~(14)~~~~(15)~~ "Registration" means an authorization issued by the department to an insurer
 12 or a private review agent to conduct utilization review;

13 ~~(15)~~~~(16)~~ "Retrospective review" means utilization review that is conducted after health
 14 care services have been provided to a covered person. "Retrospective review" does
 15 not include the review of a claim that is limited to an evaluation of reimbursement
 16 levels, or adjudication of payment;

17 ~~(16)~~~~(17)~~ (a) "Urgent health care services" means health care or treatment with
 18 respect to which the application of the time periods for making nonurgent
 19 determination:

20 1. Could seriously jeopardize the life or health of the covered person or the
 21 ability of the covered person to regain maximum function; or
 22 2. In the opinion of a physician with knowledge of the covered person's
 23 medical condition, would subject the covered person to severe pain that
 24 cannot be adequately managed without the care or treatment that is the
 25 subject of the utilization review.~~;~~ ~~and~~

26 (b) ~~["Urgent health care services include"~~ ~~shall include~~ all requests for
 27 hospitalization and outpatient surgery;

1 ~~(17)~~~~(18)~~ "Utilization review" means a review of the medical necessity and
 2 appropriateness of hospital resources and medical services given or proposed to be
 3 given to a covered person for purposes of determining the availability of payment.
 4 Areas of review include concurrent, prospective, and retrospective review; and

5 ~~(18)~~~~(19)~~ "Utilization review plan" means a description of the procedures governing
 6 utilization review activities performed by an insurer or a private review agent.

7 ➔Section 8. KRS 304.17A-603 is amended to read as follows:

8 (1) KRS 304.17A-600 to 304.17A-633 shall apply to any insurer that covers citizens of
 9 the Commonwealth under a health benefit plan.

10 (2) An insurer shall maintain written procedures for:

11 (a)~~(1)~~ Determining whether a requested service, treatment, drug, or device is
 12 covered under the terms of a covered person's health benefit plan;

13 (b)~~(2)~~ Making utilization review determinations; and

14 (c)~~(3)~~ Notifying covered persons, authorized persons, and providers acting on
 15 behalf of covered persons of its determinations.

16 (3) ***An insurer shall make the written procedures required by this section readily***
 17 ***accessible on its Web site to covered persons, authorized persons, and providers.***

18 (4) ***(a) If an insurer requires preauthorization to be obtained for a service to be***
 19 ***covered, the insurer shall maintain information on its publicly accessible***
 20 ***Web site about the list of services and codes for which preauthorization is***
 21 ***required. The Web site shall indicate, for each service required to be***
 22 ***preauthorized:***

23 ***1. When preauthorization was required, including the effective date or***
 24 ***dates and the termination date or dates, if applicable;***

25 ***2. The date the requirement was listed on the insurer's Web site; and***

26 ***3. Where applicable, the date that preauthorization was removed.***

27 ***(b) An insurer shall maintain a complete list of services for which***

1 preauthorization is required, including for all services where
 2 preauthorization is performed by an entity under contract with the insurer.

3 (c) An insurer shall not deny a claim for failure to obtain preauthorization if
 4 the preauthorization requirement was not in effect on the date of service on
 5 the claim.

6 (5) Except as otherwise provided in this subtitle, prior authorization shall not be
 7 required for births or the inception of neonatal intensive care services and
 8 notification shall not be required as a condition of payment.

9 (6) Unless otherwise specified by the provider's contract, an insurer shall not deem
 10 as incidental or deny supplies that are routinely used as part of a procedure
 11 when:

12 (a) An associated procedure has been preauthorized; or

13 (b) Preauthorization for the procedure is not required.

14 ➔Section 9. KRS 304.17A-607 is amended to read as follows:

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

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

22 (b) Ensure that, for any contract entered into on or after the effective date of
 23 this Act for the provision of utilization review services, only licensed
 24 physicians, who are of the same or similar specialty and subspecialty, when
 25 possible, as the ordering provider, shall:

26 1. Make a utilization review decision to deny, reduce, limit, or terminate a
 27 health care benefit or to deny, or reduce payment for a health care

- 1 service because that service is not medically necessary, experimental, or
2 investigational except in the case of a health care service rendered by a
3 chiropractor or optometrist where the denial shall be made respectively
4 by a chiropractor or optometrist duly licensed in Kentucky; and
- 5 2. Supervise qualified personnel conducting case reviews;
- 6 (c) Have available the services of sufficient numbers of practicing physicians in
7 appropriate specialty areas to assure the adequate review of medical and
8 surgical specialty and subspecialty cases;
- 9 (d) Not disclose or publish individual medical records or any other confidential
10 medical information in the performance of utilization review activities except
11 as provided in the Health Insurance Portability and Accountability Act,
12 Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other
13 applicable laws and administrative regulations;
- 14 (e) Provide a toll free telephone line for covered persons, authorized persons, and
15 providers to contact the insurer or private review agent and be accessible to
16 covered persons, authorized persons, and providers for forty (40) hours a week
17 during normal business hours in this state;
- 18 (f) Where an insurer, its agent, or private review agent provides or performs
19 utilization review, be available to conduct utilization review during normal
20 business hours and extended hours in this state on Monday and Friday through
21 6:00 p.m., including federal holidays;
- 22 (g) Provide decisions to covered persons, authorized persons, and all providers on
23 appeals of adverse determinations and coverage denials of the insurer or
24 private review agent, in accordance with this section and administrative
25 regulations promulgated in accordance with KRS 304.17A-609;
- 26 (h) Except for retrospective review of an emergency admission where the covered
27 person remains hospitalized at the time the review request is made, which

1 shall be considered a concurrent review, or as otherwise provided in this
 2 subtitle, provide a utilization review decision [~~relating to urgent and~~
 3 ~~nonurgent care~~] in accordance with the timeframes in paragraph (i) of this
 4 subsection and 29 C.F.R. Part 2560, including [~~the timeframes and~~] written
 5 notice of the decision[~~. A written notice in electronic format, including e-mail~~
 6 ~~or facsimile, may suffice for this purpose where the covered person,~~
 7 ~~authorized person, or provider has agreed in advance in writing to receive~~
 8 ~~such notices electronically and shall include the required elements of~~
 9 ~~subsection (j) of this section~~];

- 10 (i) 1. Render a utilization review decision concerning urgent health care
 11 services, and notify the covered person, authorized person, or provider
 12 of that decision no later than twenty-four (24) hours after obtaining
 13 all necessary information to make the utilization review decision; and
 14 2. If the insurer or agent requires a utilization review decision of
 15 nonurgent health care services, render a utilization review decision
 16 and notify the covered person, authorized person, or provider of the
 17 decision within seventy-two (72) hours of obtaining all necessary
 18 information to make the utilization review decision.
 19 For purposes of this paragraph, "necessary information" is limited to:
 20 a. The results of any face-to-face clinical evaluation;
 21 b. Any second opinion that may be required; and
 22 c. Any other information determined by the department to be
 23 necessary to making a utilization review determination[~~Provide a~~
 24 ~~utilization review decision within twenty-four (24) hours of receipt~~
 25 ~~of a request for review of a covered person's continued hospital~~
 26 ~~stay and prior to the time when a previous authorization for~~
 27 ~~hospital care will expire~~];

- 1 (j) Provide written notice of review decisions to the covered person, authorized
2 person, and providers. *The written notice may be provided in an electronic*
3 *format, including e-mail or facsimile, if the covered person, authorized*
4 *person, or provider has agreed in advance in writing to receive the notices*
5 *electronically.* An insurer or agent that denies *step therapy, as defined in*
6 *KRS 304.17A-163, overrides or denies* coverage or reduces payment for a
7 treatment, procedure, drug that requires prior approval, or device shall include
8 in the written notice:
- 9 1. A statement of the specific medical and scientific reasons for denial or
10 reduction of payment or identifying that provision of the schedule of
11 benefits or exclusions that demonstrates that coverage is not available;
 - 12 2. The ~~{state of licensure, }~~medical license number, and the title of the
13 reviewer making the decision;
 - 14 3. Except for retrospective review, a description of alternative benefits,
15 services, or supplies covered by the health benefit plan, if any; and
 - 16 4. Instructions for initiating or complying with the insurer's internal appeal
17 procedure, as set forth in KRS 304.17A-617, stating, at a minimum,
18 whether the appeal shall be in writing, and any specific filing
19 procedures, including any applicable time limitations or schedules, and
20 the position and phone number of a contact person who can provide
21 additional information;
- 22 (k) Afford participating physicians an opportunity to review and comment on all
23 medical and surgical and emergency room protocols, respectively, of the
24 insurer and afford other participating providers an opportunity to review and
25 comment on all of the insurer's protocols that are within the provider's legally
26 authorized scope of practice; and
- 27 (l) Comply with its own policies and procedures on file with the department or, if

1 accredited or certified by a nationally recognized accrediting entity, comply
 2 with the utilization review standards of that accrediting entity where they are
 3 comparable and do not conflict with state law.

4 (2) The insurer's or private review agent's failure to make a determination and provide
 5 written notice within the time frames set forth in this section shall be deemed to be
 6 a prior authorization for the health care services or benefits subject to the
 7 review~~[an adverse determination by the insurer for the purpose of initiating an~~
 8 ~~internal appeal as set forth in KRS 304.17A-617].~~ This provision shall not apply
 9 where the failure to make the determination or provide the notice results from
 10 circumstances which are documented to be beyond the insurer's control.

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

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

18 ➔Section 10. KRS 304.17A-430 is amended to read as follows:

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

22 (a) The health benefit plan was purchased by an individual to provide benefits for
 23 only one (1) or more of the following: the individual, the individual's spouse,
 24 or the individual's children. Health insurance coverage provided to an
 25 individual in the group market or otherwise in connection with a group health
 26 plan does not satisfy this criteria even if the individual, or the individual's
 27 spouse or parent, pays some or all of the cost of the coverage unless the

- 1 coverage is offered in connection with a group health plan that has fewer than
2 two (2) participants as current employees on the first day of the plan year;
- 3 (b) An individual entitled to benefits under the health benefit plan has been
4 diagnosed with a high-cost condition on or before the effective date of the
5 individual's coverage for coverage issued on a guarantee-issue basis after July
6 15, 1995;
- 7 (c) The health benefit plan imposes the maximum pre-existing condition
8 exclusion permitted under KRS 304.17A-200;
- 9 (d) The individual purchasing the health benefit plan is not eligible for or covered
10 by other coverage; and
- 11 (e) The individual is not a state employee eligible for or covered by the state
12 employee health insurance plan under KRS Chapter 18A.
- 13 (2) Notwithstanding the provisions of subsection (1) of this section, if the total claims
14 paid for the high-cost condition under a program plan for any three (3) consecutive
15 years are less than the premiums paid under the program plan for those three (3)
16 consecutive years, then the following shall occur:
- 17 (a) The policy shall not be considered to be a program plan thereafter until the
18 first renewal of the policy after there are three (3) consecutive years in which
19 the total claims paid under the policy have exceeded the total premiums paid
20 for the policy and at the time of the renewal the policy also qualifies under
21 subsection (1) as a program plan; and
- 22 (b) Within the last six (6) months of the third year, the insurer shall provide each
23 person entitled to benefits under the policy who has a high-cost condition with
24 a written notice of insurability. The notice shall state that the recipient may be
25 able to purchase a health benefit plan other than a program plan and shall also
26 state that neither the notice nor the individual's actions to purchase a health
27 benefit plan other than a program plan shall affect the individual's eligibility

1 for plan coverage. The notice shall be valid for six (6) months.

2 (3) (a) There is established within the guaranteed acceptance program the alternative
3 underwriting mechanism that a participating insurer may elect to use. An
4 insurer that elects this mechanism shall use the underwriting criteria that the
5 insurer has used for the past twelve (12) months for purposes of the program
6 plan requirement in paragraph (b) of subsection (1) of this section for high-
7 risk individuals rather than using the criteria established in KRS 304.17A-
8 005~~[(24)]~~ and 304.17A-280 for high-cost conditions.

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

15 ➔Section 11. This Act takes effect January 1, 2020.