AN ACT relating to out-of-network balance billing.

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

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

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

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

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

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) ***"Balance billing" or "balance bill" means the practice by a nonparticipating provider of charging a covered person the difference between the provider's fee and the sum of:***

(a) What the covered person's health benefit plan pays; and

(b) What the covered person is required to pay in cost-sharing;

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(5) ~~[(4)]~~ "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient

hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

(6) ~~[(5)]~~ "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(7) ~~[(6)]~~ "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(8) ~~[(7)]~~ "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(9) (a) ~~[(8)]~~ ***"Cost-sharing" means any expenditure required to be paid by or on behalf of a covered person with respect to receiving benefits or services under a health insurance plan or policy, including a health benefit plan.***

(b) Cost-sharing includes coinsurance, deductibles, and copayments.

(c) Cost-sharing does not include premiums, balance billings, or spending for noncovered services;

(10) "Covered person" means an individual entitled to receive benefits or services under a health benefit plan;

(11) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting

solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;

9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or

11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program.

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in~~[subsection (14) of]~~ this section;

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

(13) "Emergency health care services" means health care services that are provided in a health facility after the sudden onset of an emergency medical condition;

(14) "Emergency medical condition" means:

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

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

2. Serious impairment to bodily functions; or

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

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

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

2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;

(15) ~~[(10)]~~ "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;

(16) ~~[(11)]~~ "Eligible individual" means an individual:

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

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

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

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

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(17) ~~[(12)]~~ "Employer-organized association" means any of the following:

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

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

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

Except as provided in KRS 304.17A-200~~[, 304.17A.210,]~~ and 304.17A-220, and

except as otherwise provided by the definition of "large group" ***in***~~[contained in subsection (30) of]~~ this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in~~[~~ ~~subsection (5) of]~~ this section shall be treated as a large group under this subtitle;

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

(19)~~[(14)]~~ "Excepted benefits" means benefits under one (1) or more, or any combination ~~[thereof]~~, of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-

based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

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

(21) ~~[(16)]~~ "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(22) ~~[(17)]~~ "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(23) ~~[(18)]~~ "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

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

(25) ~~[(20)]~~ "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

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

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

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

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

3. The individual engaged in intentional and abusive noncompliance with

health benefit plan provisions;

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

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

1. Hospital or medical expense policy or certificate;

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

3. Provider sponsored integrated health delivery network;

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

5. Health maintenance organization contract***, except contracts to provide Medicaid benefits under KRS Chapter 205***; or

6. ~~[Any]~~Health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky***.***~~[, and]~~

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

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

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

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

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

5. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability

insurance policy or equivalent self-insurance**;**~~[,]~~

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

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

8. Medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract**;**~~[, or]~~

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

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

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

12. Coverage provided under KRS Chapter 205;

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

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

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

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

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

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

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

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

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

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

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

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

(b) Health care services include the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

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

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

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

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the

conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

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

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

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

(34) "In-network facility" means a health facility that has entered into an agreement with a covered person's insurer to provide health care services to the covered person;

(35) ~~[(27)]~~ "Insurer" means any insurance company; health maintenance organization;

self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

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

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

(38) ~~[(30)]~~ "Large group" means:

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

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) An employer-organized association that is a bona fide association as defined in~~[subsection (5) of]~~ this section;

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

(40) ~~[(32)]~~ "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

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

(42) "Out-of-network facility" means a health facility that has not entered into an agreement with a covered person's insurer to provide health care services to the covered person;

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

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

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

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

(47) ~~[(36)]~~ "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

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

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

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

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

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

(53) ~~[(42)]~~ "Small group" means:

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

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

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

(55) ~~[(44)]~~ "Telehealth":

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

to the telehealth encounter;

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

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

(56) "Usual, customary, and reasonable rate" means the eightieth percentile of all charges for a particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area as reported under Section 2 of this Act.

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

(1) The commissioner shall, by promulgating administrative regulations:

(a) Specify a nonprofit organization that maintains a database of billed charges submitted by providers for health care services to be used as a benchmark for determining the usual, customary, and reasonable rate for health care services. The nonprofit shall not be affiliated with an insurer offering health benefit plans in Kentucky; and

(b) Require all insurers offering health benefit plans in Kentucky to submit to the department annually, but no later than March 1 of each year, all of the billed charges it receives from both participating and nonparticipating providers for each health care service.

(2) Any information required to be reported under this section shall:

(a) Be reported on a form and in a manner determined by the commissioner;

(b) Not include any personally identifying information of a covered person; and

(c) Include appropriate geographical information of the billing provider.

(3) The department shall provide information reported under this section to the

nonprofit identified in subsection (1) of this section. If no nonprofit exists meeting the requirements of subsection (1) of this section, then the department shall publish this information in a report on its Web site by June 1 of each year.

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

An insurer that offers a health benefit plan that is not a managed care plan ***as defined in Section 18 of this Act,*** but provides financial incentives for a covered person to access a network of providers shall:

(1)~~[Notify the covered person, in writing, of the availability of a printed document, in a manner consistent with KRS 304.14-420 to 304.14-450, containing the following information at the time of enrollment and upon request:~~

~~(a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider, professional office address, telephone number, and specialty designations of the network provider, if any; and~~

~~(b) In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format;~~

~~(2)~~] ***Ensure***~~[Assure]~~ that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be~~[balanced]~~ billed by the ***participating***~~[in-network]~~ provider except for ***cost-sharing***~~[deductibles, co-pays, coinsurance amounts,]~~ and noncovered benefits;

(2)~~[(3)]~~ ***(a) Have a process for the selection of health care providers who will be on each health benefit plan's list of participating providers, with written policies and procedures for review and approval used by the insurer;***

(b) Establish minimum professional requirements for participating health care providers;

(c) Not discriminate against a health care provider solely on the basis of the provider's license by the state; and

(d) Ensure that each health benefit plan's network of participating providers:

1. Is adequate to meet the health care needs of covered persons; and

2. Provides an appropriate choice of participating providers at each in-network health facility sufficient to render the health care services covered by the plan~~[File with the department a copy of the directory required under subsection (1) of this section;~~

~~(4) Have a process for the selection of health care providers who will be on the insurer's list of participating providers, with written policies and procedures for review and approval used by the insurer. The insurer shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state~~];

(3)~~[(5)]~~ Not contract with a health care provider to limit the provider's disclosure to a covered person, or to another person on behalf of a covered person, of any information relating to the covered person's medical condition or treatment options;

(4)~~[(6)]~~ Not penalize a health care provider, or terminate a health care provider's contract with the insurer, because the provider discusses medically necessary or appropriate care with a covered person or another person on behalf of a covered person. The health care provider may:

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

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

(5)~~[(7)]~~ Include in any agreements it enters into with providers for the provision of

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

(6)~~[(8)]~~ Establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board; and

(7)~~[(9)]~~ Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS 304.17A-700 to 304.17A-730.

➔Section 4. KRS 304.17A-510 is amended to read as follows:

(1) In addition to the disclosure requirements provided in KRS 304.17A-505, an insurer

that offers a ***health benefit***~~[managed care]~~ plan ***that requires, or provides financial incentives for, covered persons to access a network of providers*** shall notify ***covered persons***~~[an enrollee]~~, in writing, of the availability of a printed document ***and an electronic document on its Web site***, in a manner consistent with KRS 304.14-420 to 304.14-450, containing the following information at the time of enrollment and ***thereafter,*** upon request:

(a) A current participating provider directory providing information on a covered person's access to primary care ***physicians and specialists, optometrists, chiropractors, and hospitals***~~[health care providers]~~, including available participating health care providers, by provider category or specialty and by county. The directory shall include***:***~~[the professional office address of each participating health care provider. The directory shall also provide information about participating hospitals and other providers. The insurer shall promptly notify each covered person on the termination or withdrawal from the insurer's provider network of the covered person's designated primary care provider;]~~

1. For health care providers except hospitals:

a. Name, specialty, participating locations, contact information, and whether the provider is accepting new patients; and

b. If applicable, languages spoken other than English, facility type, and types of health care services provided at the facility; and

2. For hospitals, name, telephone number, hospital type, and participating locations; and

(b) ***For managed care plans and risk-bearing managed care plans:***

1. General information about the type of financial incentives between participating providers under contract with the insurer and other participating health care providers and facilities to which the participating providers refer their managed care patients;

2.~~[(c)]~~ ***Grievance procedures available under the plan for complaint resolution;***

3. The~~[insurer's managed care]~~ plan's standard for customary waiting times for appointments for urgent and routine care; and

4.~~[(d)]~~ The existence of any hold harmless agreements it has with providers and their effect on ***covered persons***~~[the enrollee]~~.

~~[The insurer shall provide a prospective enrollee with information about the provider network, including hospital affiliations, and other information specified in this subsection, upon request. In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format.]~~

(2) ***An insurer that offers a managed care plan or a risk-bearing managed care plan shall promptly notify each covered person upon the termination or withdrawal of the covered person's designated primary care provider from the insurer's network of participating providers.***

(3) Upon request of a covered person, an insurer shall promptly inform the person:

(a) Whether a particular ***participating***~~[network]~~ provider is board certified; and

(b) Whether a particular ***participating***~~[network]~~ provider is currently accepting new patients.

(4)~~[(3)]~~ Each insurer ***that offers a managed care plan*** shall annually make available to its enrollees at its principal office and place of business:

(a) Its most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements; and

(b) A current description of its organizational structure and operation.

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

(a) With respect to the provider directory required under subsection (1) of this section:

1. File a copy of the directory with the department; and

2. Make the directory available on its Web site and in print format; and

(b) Audit, annually, at least a reasonable sample size of its provider directories for accuracy and retain documentation of each audit to be made available to the commissioner upon request.

(6) The provider directory required under subsection (1) of this section shall include the following general information in plain language for each network of participating providers:

(a) A description of the criteria the insurer used to build its network and, if applicable, to tier providers;

(b) If applicable, a description of how the insurer designates the different provider tiers or levels in the network and identifies for each participating provider, which tier the provider is placed in;

(c) If applicable, a statement that authorization or referral may be required to access some providers;

(d) Clear identification of which provider directory applies to each health benefit plan; and

(e) A customer service e-mail address and telephone number or electronic link that covered persons or the public may use to notify the insurer of inaccurate provider directory information.

(7) For the provider directory required under subsection (1) of this section that is posted on the insurer's Web site, the insurer shall:

(a) Update the directory at least monthly;

(b) Ensure that the public is able to view a health benefit plan's current participating providers through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number; and

(c) Include the information required in subsection (1)(a) of this section and the following additional information in searchable format for each network of participating providers:

1. For health care providers except hospitals, gender, board certifications, and, if applicable, medical group and health facility affiliations; and

2. For hospitals, accreditation status.

(8) For the provider directory required under subsection (1) of this section that is in print format, the insurer shall include a disclosure that the directory is accurate as of the date of printing and that covered persons and prospective covered persons should access the provider directory on the insurer's Web site or call the insurer at a customer service telephone number provided by the insurer to obtain current provider directory information.

➔SECTION 5. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

All health benefit plans issued or renewed on or after the effective date of this Act shall provide coverage for the following:

(1) Access by a covered person to a nonparticipating provider with the plan's prior authorization when the health benefit plan does not have a participating provider:

(a) That is geographically accessible to the covered person; and

(b) Has appropriate training and experience to meet the particular health care needs of the covered person;

(2) (a) Direct access by a covered person, without the need for a referral, to primary and preventive obstetric and gynecologic services from a qualified provider.

(b) For the purposes of this subsection, "primary and preventive obstetric and

gynecologic services" includes:

1. Annual examinations and pap smears;

2. Care resulting from annual examinations and pap smears;

3. Treatment of acute gynecologic conditions; and

4. Any health care service related to a pregnancy;

(3) Upon request, access by a covered person to a specialist under a standing referral, if the person has a condition that requires ongoing care from the specialist; and

(4) Upon request, access by a covered person to the following, if the person has a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized health care services over a prolonged period of time:

(a) A specialist responsible for providing or coordinating the covered person's health care services; and

(b) A specialty care center.

➔SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) An insurer that offers a health benefit plan that requires, or provides financial incentives for, covered persons to access a network of providers shall, before use, file with the commissioner its plan.

(2) The commissioner shall review each plan for network adequacy:

(a) At the time of initial filing;

(b) At least every three (3) years thereafter; and

(c) Upon expansion of any service area associated with the plan.

(3) A health benefit plan's network shall be deemed adequate if the commissioner determines that the plan satisfies all applicable requirements contained in Sections 3 and 5 of this Act, and KRS 304.17A-515.

(4) Nothing in this section shall limit the authority of the commissioner under any other law.

➔Section 7. KRS 304.17A-550 is amended to read as follows:

(1) ***(a)*** An insurer that offers a managed care plan shall offer a health benefit plan with out-of-network benefits to every contract holder. The plan with out-of-network benefits shall allow a covered person to receive covered services from out-of-network health care providers without having to obtain a referral. The plan with out-of-network benefits may require that an enrollee pre-certify selected services and pay a higher deductible, copayment, coinsurance, excess charges and higher premium for the out-of-network benefit plan pursuant to limits established by administrative regulations promulgated by the department.

(b)~~[(2)]~~ If the contract holder elects the out-of-network offering required under ***paragraph (a)***~~[subsection (1)]~~ of this ***subsection***~~[section]~~, the insurer shall provide each enrollee with the opportunity at the time of enrollment and during the annual open enrollment period, to enroll in the out-of-network option. If the contract holder elects the out-of-network offering required under ***paragraph (a)***~~[subsection (1)]~~ of this ***subsection***~~[section]~~, the insurer and the contract holder shall provide written notice of the benefit plan with out-of-network benefits to each enrollee in a plan and shall include in that notice a detailed explanation of the financial costs to be incurred by an enrollee who selects the plan.

(2) (a) An insurer that offers a group health benefit plan that provides comprehensive coverage of health care services provided by nonparticipating providers shall make available and, if requested by the policy holder or contract holder, offer at least one (1) option for comprehensive coverage of health care services provided by

nonparticipating providers at a rate of at least eighty percent (80%) of the usual, customary, and reasonable rate for each covered health care service, after imposition of a deductible or any permissible benefit maximum.

(b) If there is no coverage available under paragraph (a) of this subsection in a rating region, then the commissioner may require an insurer that offers a group health benefit plan that provides comprehensive coverage for health care services in the rating region to make available and, if requested by the policyholder or contract holder, offer at least one (1) health benefit plan that provides comprehensive coverage for health care services provided by nonparticipating providers at a rate of at least eighty percent (80%) of the usual, customary, and reasonable rate for each covered health care service, after imposition of a deductible or any permissible benefit maximum.

(c) The commissioner may:

1. After considering the public interest, permit an insurer to satisfy the requirements of this subsection on behalf of another insurer within the same holding company system; and

2. Upon written request, waive the requirements of this subsection if the commissioner determines that it would pose an undue hardship upon an insurer.

(d) This subsection shall not apply to emergency health care services.

(3) ***Nothing in this section shall limit the authority of the commissioner under any other law***[~~The requirement of this section shall not apply to an insurer contract which offers a managed care plan that provides health care services solely to Medicaid or Medicare recipients.~~

~~(4) Managed care plans currently licensed and doing business in Kentucky that do not yet offer benefit plans with out-of-network benefits must develop and offer those plans within three hundred sixty-five (365) days of April 10, 1998~~].

➔Section 8. KRS 304.17A-580 is amended to read as follows:

(1) ***(a)*** An insurer offering health benefit plans shall***:***

1. Educate its insureds about the availability, location, and appropriate use of emergency and other medical services, cost-sharing provisions for emergency services, and the availability of care outside an emergency department***;***~~[.]~~

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

3. Ensure that covered persons incur no greater out-of-pocket costs for emergency health care services provided by a nonparticipating provider than the covered person would incur if the services were provided by a participating provider.

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

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

(2) (a) Where a covered person with an emergency medical condition has been

stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 42 U.S.C. sec. 1395dd, in the emergency department of an out-of-network facility, and an insurer under its health benefit plan requires prior authorization for poststabilization treatment, approval or denial under the preauthorization requirement shall be provided in a timely manner appropriate to conditions of the patient and delivery of the services, but in no case to exceed two (2) hours from the time the request is made and all relevant information is provided. The insurer's failure to make a determination within the two (2) hour timeframe shall constitute an authorization for the health facility to provide the medical service for which prior authorization was sought.

(b) The out-of-network facility providing emergency health care services, poststabilization treatment, or both, shall be paid at a rate negotiated between the out-of-network facility and the insurer. Nothing in this section is to be construed as requiring the payment of one hundred percent (100%) of the billed charges.

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

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

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

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

(b) Ensure that only licensed physicians shall:

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

2. Supervise qualified personnel conducting case reviews;

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

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

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

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

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

regulations promulgated in accordance with KRS 304.17A-609;

(h) ***1.*** Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, provide a utilization review decision relating to urgent and nonurgent care in accordance with 29 C.F.R. Part 2560, including the timeframes and written notice of the decision. A written notice in electronic format, including e-mail or facsimile, may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive ***the*** ~~[such]~~ notices electronically and shall include the required elements of subsection (j) of this section***.***

2. Unless a shorter time is provided in any other provision of this section, a health benefit plan shall provide utilization review decisions involving nonparticipating providers that require prior authorization within three (3) business days of receipt of the information necessary to make the decision;

(i) Provide a utilization review decision within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire;

(j) ***1.*** Provide written notice of review decisions to the covered person, authorized person, and providers.

2. In addition to the requirements of subparagraph 3. of this paragraph, and, to the extent practicable, for review decisions that involve nonparticipating providers that require prior authorization under Section 5 of this Act, the written notice shall include:

a. Whether the proposed health care services by the nonparticipating provider will be treated as in-network or out-of-

network;

b. Whether the covered person will be responsible for any payment for the proposed health care services other than applicable cost-sharing under the health benefit plan;

c. As applicable, the dollar amount the health benefit plan will pay for the health care services if they are treated as out-of-network; and

d. As applicable, information explaining how a covered person can determine the anticipated out-of-pocket cost for the proposed health care services in a geographical area or zip code based upon the difference between what the health benefit plan will pay for the health care services if they are treated as out-of-network and the usual, customary, and reasonable rate for the proposed health care services.

3. An insurer or agent that denies coverage or reduces payment for a treatment, procedure, drug ***or nonparticipating provider*** that requires prior ***authorization***~~[approval]~~, or device shall include in the written notice:

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

b.~~[2.]~~ The state of licensure, medical license number, and the title of the reviewer making the decision;

c.~~[3.]~~ Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

d. ~~[4.]~~ Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, ***what information must be submitted with the appeal,*** and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information~~[;]~~**.**

4. The denial of prior authorization to access a nonparticipating provider under Section 5 of this Act shall not constitute an adverse determination.

5. An appeal of a denial of prior authorization to access a nonparticipating provider under Section 5 of this Act shall be accompanied by a written statement from the covered person's attending provider, who shall be a licensed, board-certified or board-eligible physician qualified to practice in the specialty appropriate to treat the covered person for the health care services sought, that:

a. The participating providers in the covered person's health benefit plan do not have appropriate training and experience to meet the particular health care needs of the covered person; and

b. The attending provider recommends a nonparticipating provider or providers with the appropriate training and experience to meet the particular needs of the covered person and who are able to provide the health care services sought;

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

authorized scope of practice; and

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

(2) The insurer's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

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

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

➔Section 10. KRS 304.17A-617 is amended to read as follows:

(1) Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j). For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the

covered person's health benefit plan. Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person. The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal;

(b) Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part;

(c) Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial.

However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(d) Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information; and

(e) ***1.*** In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, ***nonparticipating provider,*** or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

a. ~~[1.]~~ A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

b. ~~[2.]~~ The state of licensure, medical license number, and the title of the person making the decision;

c. ~~[3.]~~ Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

d. ~~[4.]~~ Instructions for initiating an external review~~[of an adverse determination,]~~ or filing a request for review with the department

if ***an adverse determination or*** a coverage denial is upheld by the insurer on internal appeal.

2. An insurer that upholds the denial of prior authorization for access to a nonparticipating provider under Section 5 of this Act on internal appeal shall afford the covered person an opportunity for external review under Section 11 of this Act, KRS 304.17A-623, and Section 12 of this Act.

(3) The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers. For purposes of this subsection, "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

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

(b) Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

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

(d) On the receipt of the information described in paragraphs (b) and (c) of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

(e) An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph (d) of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(f) If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days, or provide the covered person the

opportunity for external review.

➔Section 11. KRS 304.17A-621 is amended to read as follows:

(1) The Independent External Review Program is hereby established in the department.

(2) The program shall provide covered persons with a formal, independent review to address disagreements between the covered person and the covered person's insurer regarding***:***

(a) An adverse determination made by the insurer, its designee, or a private review agent***; or***

(b) A coverage denial from which the covered person is afforded an opportunity for external review under Section 10 of this Act.

(3) This section and KRS 304.17A-623 and 304.17A-625 establish requirements and procedures governing external review and independent review entities.

➔Section 12. KRS 304.17A-625 is amended to read as follows:

(1) In making its decision, an independent review entity conducting the external review shall take into account all of the following:

(a) Information submitted by the insurer, the covered person, the authorized person, and the covered person's provider, including the following:

1. The covered person's medical records;

2. The standards, criteria, and clinical rationale used by the insurer to make its decision; and

3. The insurer's health benefit plan;

(b) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, or any board recognized by the National Institutes of Health, the National Cancer Institute, the National Academy of Sciences, and the United States Food and Drug Administration, the Centers for Medicare & Medicaid Services of the United States Department of Health and Human

Services, and the Agency for Health Care Research and Quality;~~[and]~~

(c) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical specialists, and clinical guidelines adopted by relevant national medical societies***; and***

(d) For denials of prior authorization for access to a nonparticipating provider under Section 5 of this Act, the following additional information shall be considered:

1. The training and experience of:

a. The participating provider or providers proposed by the health benefit plan; and

b. The nonparticipating provider or providers requested by the covered person;

2. The attending provider's recommendation; and

3. Any other relevant information.

(2) The independent review entity shall base its decision on the information submitted under subsection (1) of this section. In making its decision, the independent review entity shall consider safety, appropriateness, and cost effectiveness.

(3) The insurer shall provide any coverage determined by the independent review entity to be medically necessary. The independent review entity shall not be permitted to allow coverage for services specifically limited or excluded by the insurer in its health benefit plan. The decision shall apply only to the individual covered person's external review.

(4) Nothing in this section shall be construed as requiring an insurer to provide coverage for out of network services, procedures, or tests, except as set forth in ***Section 5 of this Act,*** KRS 304.17A-515(1)(c)***,*** and ***KRS*** 304.17A-550.

(5) The insurer shall be responsible for the cost of the external review.

(6) The independent review entity shall provide to the covered person, treating

provider, insurer, and the department a decision which shall include:

(a) The findings for either the insurer or covered person regarding each issue under review;

(b) The proposed service, treatment, drug, device, or supply for which the review was performed;

(c) The relevant provisions in the insurer's health benefit plan and how applied; and

(d) The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

(7) The decision of the independent review entity shall not be made solely for the convenience of the insurer, the covered person, or the provider.

(8) Consistent with the rules of evidence, a written decision prepared by an independent review entity shall be admissible in any civil action related to the adverse determination. The independent review entity's decision shall be presumed to be a scientifically valid and accurate description of the state of medical knowledge at the time it was written.

(9) The decision of the independent review entity shall be binding on the insurer with respect to that covered person. Failure of the insurer to provide coverage as required by the independent review entity shall:

(a) Be a violation of the insurance code of a nature sufficient to warrant the commissioner revoking or suspending the insurer's license or certificate of authority; and

(b) Constitute an unfair claims settlement practice as set forth in KRS 304.12-230.

(10) Failure to provide coverage as required by the independent review entity shall also subject the insurer to the provisions of KRS 304.99-010 and 304.99-020 and require the insurer to pay the claim that was the subject of the external review, without need

for the covered person or authorized person to further establish a right as to the payment amount. Reasonable attorney fees associated with the actions of the insured necessary to collect amounts owed the covered person shall be assessed against and borne by the insurer.

(11) The insurer shall implement the decision of the independent review entity whether the covered person has disenrolled or remains enrolled with the insurer.

(12) If the covered person has been disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was previously denied by the insurer, its agent, or designee and later approved by the independent review entity for a period not to exceed thirty (30) days.

(13) Within thirty (30) days of the decision in favor of the covered person by the independent review entity, the insurer shall provide written notification to the department that the decision has been implemented in accordance with this section.

(14) An independent review entity and any medical specialist the entity utilizes in conducting an external review shall not be liable in damages in a civil action for injury, death, or loss to person or property and is not subject to professional disciplinary action for making, in good faith, any finding, conclusion, or determination required to complete the external review. This subsection does not grant immunity from civil liability or professional disciplinary action to an independent review entity or medical specialist for an action that is outside the scope of authority granted in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(15) Nothing in KRS 304.17A-600 to 304.17A-633 shall be construed to create a cause of action against any of the following:

(a) An employer that provides health care benefits to employees through a health benefit plan;

(b) A medical expert, private review agent, or independent review entity that participates in the utilization review, internal appeal, or external review

addressed in KRS 304.17A-600 to 304.17A-633; or

(c) An insurer or provider acting in good faith and in accordance with any finding, conclusion, or determination of an Independent Review Entity acting within the scope of authority set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625.

(16) The covered person, insurer, or provider in the external review may submit written complaints to the department regarding any independent review entity's actions believed to be an inappropriate application of the requirements set forth in KRS 304.17A-621, 304.17A-623, and 304.17A-625. The department shall promptly review the complaint, and if the department determines that the actions of the independent review entity were inappropriate, the department shall take corrective measures, including decertification or suspension of the independent review entity from further participation in external reviews. The department's actions shall be subject to the powers and administrative procedures set forth in Subtitle 17A of KRS Chapter 304.

➔SECTION 13. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) A health benefit plan, at a minimum, shall provide the following notices to covered persons on its Web site:

(a) Notice of the coverage required under Section 5 of this Act, as well as the procedures for requesting and obtaining the coverage provided;

(b) A clear description of the methodology used by the plan to determine reimbursement for health care services provided by nonparticipating providers;

(c) A description of the amount the insurer will reimburse for health care services provided by nonparticipating providers set forth as a percentage of the usual, customary, and reasonable rate for the health care services;

(d) Examples of anticipated out-of-pocket costs for frequently billed health care services provided by nonparticipating providers; and

(e) Information that reasonably permits a covered person to estimate the anticipated out-of-pocket costs for health care services provided by nonparticipating providers in a geographical area or zip code based upon the difference between the amount the insurer will reimburse for health care services provided by nonparticipating providers and the usual, customary, and reasonable rate for the health care services.

(2) Upon request of a covered person and no later than forty-eight (48) hours after the covered person has received preadmission certification to receive nonemergency health care services at a health facility, an insurer offering a health benefit plan shall provide, by electronic or written correspondence, information on:

(a) Whether the covered person's provider is a participating provider;

(b) Whether proposed nonemergency health care services are covered by the health benefit plan; and

(c) What the covered person's applicable cost-sharing will be under the health benefit plan.

➔SECTION 14. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "covered health care services" means health care services that are covered under the covered person's health benefit plan.

(2) A binding program of independent dispute resolution for disputed charges, including balance billings, for covered health care services provided by a nonparticipating provider to a covered person shall be established and administered by the commissioner in accordance with this section.

(3) The commissioner:

(a) May charge the parties participating in an independent dispute resolution proceeding a fee to cover the costs of implementation and administration of the independent dispute resolution program;

(c) Shall maintain a list of qualified reviewers;

(d) Shall establish an application process and fee schedule for qualified reviewers;

(e) May establish a filing deadline for initiating a proceeding; and

(f) Shall promulgate administrative regulations for the implementation and administration of this section.

(4) (a) Each qualified reviewer shall be approved by the commissioner. To be eligible to serve as a qualified reviewer, an individual shall:

1. Be knowledgeable and experienced in applicable principles of contract, insurance law, and the healthcare industry generally; and

2. Not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision.

(b) For the purposes of this subsection, a "conflict of interest" includes but is not limited to current or recent ownership or employment of either the individual or the individual's close family member in a health benefit plan or a health care provider involved in an independent dispute resolution proceeding.

(c) The commissioner shall terminate the approval of a qualified reviewer who no longer meets the requirements of this subsection.

(5) (a) A health benefit plan or nonparticipating provider may initiate a proceeding under this section to determine the amount payable by the health benefit plan for covered health care services provided by the nonparticipating provider to a covered person.

(b) A covered person may initiate a proceeding under this section to determine

the amount payable by the covered person for covered health care services provided by the nonparticipating provider to the covered person if the covered person receives a balance billing from the nonparticipating provider.

(c) Each initiating submission and responsive submission shall contain:

1. A proposed binding award amount for the covered health care services in dispute; and

2. If desired, a request for oral hearing.

(d) Failure to respond within fifteen (15) days to the initiating submission shall constitute acceptance of the initiating party's proposed binding award amount.

(6) If the parties have not designated a qualified reviewer approved by the commissioner within thirty (30) days of the initiating submission, the commissioner shall select a qualified reviewer from his or her list, who shall serve as the qualified reviewer in the proceeding.

(7) (a) If an oral hearing is requested by either party, the qualified reviewer shall conduct a hearing and may make procedural rulings prior to rendering a decision under subsection (8) of this section.

(b) If no oral hearing is requested, the qualified reviewer shall set a date for the submission of all information to be considered by the reviewer.

(c) The parties shall not be entitled to discovery in a proceeding conducted under this section.

(d) The qualified reviewer shall render a decision under subsection (8) of this section within ten (10) days of a hearing or submission.

(8) (a) The qualified reviewer shall choose a final binding award amount from among the two (2) proposed binding award amounts submitted by the parties.

(b) The final binding award amount shall be the proposed binding award amount submitted by the party that is closest to the reasonable charge determined by the reviewer under paragraph (c) of this subsection, with no deviation.

(c) Each qualified reviewer shall determine the reasonable charge for the health care services provided to the covered person by the nonparticipating provider. The basis for this determination shall include but not be limited to:

1. Whether there is a gross disparity between the amount charged and:

a. Amounts paid to the nonparticipating provider for the same health care services provided by the provider to other covered persons with health benefit plans in which the provider is not a participating provider; and

b. In the case of a dispute involving a health benefit plan, fees paid by the health benefit plan to reimburse similarly qualified nonparticipating providers for the same services in the same geographical area;

2. The level of training, education, and experience of the nonparticipating provider;

3. The nonparticipating provider's usual charge for comparable services provided to covered persons with health benefit plans in which the provider is not a participating provider;

4. The circumstances and complexity of the particular health care services provided, including time and place of service;

5. Individual patient characteristics; and

6. The usual, customary, and reasonable rate for the health care service provided.

(d) 1. For proceedings involving a health benefit plan and a nonparticipating provider, the health benefit plan shall pay the final award amount less any cost-sharing that would be payable by the covered person under the terms of the health benefit plan.

2. For proceedings involving a covered person and a nonparticipating provider, the covered person shall pay the final award amount less any amounts that would be payable by the covered person's health benefit plan under the terms of the plan.

(9) Unless otherwise agreed by the parties, each party shall:

(a) Bear its own attorney fees and costs; and

(b) Split the fee and costs of the qualified reviewer.

(10) The decision of the qualified reviewer shall be binding on the parties. The prevailing party may seek enforcement of the decision in any court of competent jurisdiction.

➔SECTION 15. A NEW SECTION OF KRS CHAPTER 367 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) The following have the same meaning as in Section 1 of this Act:

1. "Balance bill";

2. "Covered person";

3. "Health benefit plan";

4. "Health care provider" or "provider";

5. "Health care service";

6. "Health facility" or "facility";

7. "Nonparticipating provider"; and

8. "Participating provider";

(b) "Covered health care services" means health care services that are covered

under the covered person's health benefit plan; and

(c) "Facility-based provider" means an individual or group of health care providers:

1. To whom a health facility has granted clinical privileges; and

2. Who provide health care services to patients at the health facility under those clinical privileges.

(2) A health care provider or the provider's representative shall disclose to covered persons prior to the provision of nonemergency health care services:

(a) The health benefit plans in which the provider is a participating provider; and

(b) The hospitals with which the provider is affiliated.

(3) The disclosures required by subsection (2) of this section shall be provided:

(a) Verbally at the time an appointment is scheduled and in writing at the time of appointment; or

(b) Through the provider's Web site.

(4) (a) Prior to providing nonemergency health care services to a covered person, a nonparticipating provider shall:

1. Provide notice to the covered person that the person may request the amount or estimated amount the provider will bill the covered person for the nonemergency health care services; and

2. Upon request, provide the covered person with a written amount or estimated amount the provider anticipates billing the covered person for the nonemergency health care services.

(b) Nothing in this subsection shall apply to emergency medical conditions or unforeseen medical conditions or circumstances that arise during the provision of nonemergency health care services.

(c) The provider shall provide notice to covered persons that the written

amount or estimate provided under this subsection does not include charges that may be incurred by the covered person due to emergency medical conditions or unforeseen medical conditions or circumstances that arise during the provision of nonemergency health care services.

(5) (a) The information required by paragraph (b) of this subsection shall be given to a covered person if nonemergency health care services provided to the covered person in a health facility:

1. Require the initiation of a referral to, or coordination with, a provider referenced in paragraph (c) of this subsection; or

2. Involve a provider referenced in paragraph (c) of this subsection.

(b) A provider or provider's representative shall provide the following information, in writing, about the providers referenced in paragraph (c) of this subsection:

1. The provider's name, practice name, mailing address, and telephone number; and

2. How to determine the health benefit plans in which the provider is a participating provider.

(c) Paragraph (b) of this subsection shall apply to the following providers:

1. Anesthesiologists;

2. Laboratories;

3. Pathologists;

4. Radiologists; and

5. Assistant surgeons.

(d) The disclosure required by paragraph (a) of this subsection shall be provided by a provider or provider's representative at the time the provider or provider's representative:

1. Initiates a referral or coordination of services; or

2. Schedules a covered person to receive nonemergency health care services in a health facility.

(6) A health facility shall establish, update, and make public through posting on its Web site, to the extent required by federal guidelines, a list of the facility's standard charges for items and health care services provided by the facility, including for diagnosis-related groups established under Section 1886(d)(4) of the Social Security Act, 42 U.S.C. sec. 1395ww.

(7) A health facility shall post on its Web site:

(a) The health benefit plans in which the facility is a participating provider;

(b) A statement that:

1. Health care services provided in the health facility are not included in the facility's charges;

2. Health care providers that provide health care services in the facility may or may not participate in the same health benefit plans as the health facility;

3. If a covered person receives health care services in the facility from a nonparticipating provider, the covered person may receive a balance billing from the nonparticipating provider; and

4. A covered person should check with the provider arranging health care services for the person in the health facility to determine whether the provider is a participating provider; and

(c) As applicable, the name, mailing address, and telephone number of the facility-based providers that the facility has employed or contracted with to provide health care services in the facility and instructions about how to determine the health benefit plan in which a facility-based provider is a participating provider.

(8) In registration or admission materials provided to covered persons prior to the

provision of nonemergency health care services at a health facility, the facility shall:

(a) Advise the covered person to check with the provider arranging for the health care services to determine the name, practice name, mailing address, and telephone number of any other provider that is reasonably anticipated to provide health care services to the covered person at the health facility, including but not limited to facility-based providers; and

(b) Inform the covered person about how to timely determine the health benefit plan in which a facility-based provider is a participating provider.

(9) If a nonparticipating provider balance bills a covered person for covered health care services that are nonemergency health care services, the provider shall:

(a) 1. Not furnish, or cause to be furnished, adverse information to a consumer reporting agency if the covered person:

a. Owes the provider more than two hundred dollars ($200) in addition to any cost-sharing payable to the provider by the covered person;

b. Agrees to a payment plan; and

c. Substantially complies with the terms of the payment plan within:

i. Six (6) months of the provision of the covered health care services to the covered person; or

ii. Thirty (30) days of receiving the first balance billing that reflects all insurance payments and the final amount owed by the covered person.

2. A covered person may be considered out of substantial compliance by the nonparticipating provider if payments in compliance with the payment plan have not been made for a period of forty-five (45) days;

and

(b) Provide the following to the covered person:

1. An itemized listing of the nonemergency health care services provided, along with the dates the services were provided;

2. A conspicuous, plain-language explanation that:

a. The provider is not a participating provider in the covered person's health benefit plan; and

b. The covered person's health benefit plan has paid a rate, as determined by the health benefit plan, that is below the provider's billed amount;

3. A telephone number to call to:

a. Discuss the bill;

b. Provide an explanation of acronyms, abbreviations, and numbers used on the statement; and

c. Discuss any payment issues;

4. A statement that the covered person may call to discuss alternative payment arrangements; and

5. A notice to the covered person that he or she:

a. May file complaints with the Kentucky State Board of Medical Licensure, along with the mailing address and complaint telephone number of the board;

b. May initiate a binding independent dispute resolution proceeding under Section 14 of this Act with the Kentucky Department of Insurance, along with the mailing address and telephone number for the department; and

c. Has the rights set forth in paragraph (a) of this subsection.

➔Section 16. KRS 304.17A-096 is amended to read as follows:

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group, and employer-organized association markets. A basic health benefit plan shall cover physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist.

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

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

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

➔Section 17. KRS 304.17A-430 is amended to read as follows:

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

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health

plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

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

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

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

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

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

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

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also

state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

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

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

➔Section 18. KRS 304.17A-500 is amended to read as follows:

As used in KRS 304.17A-500 to ***304.17A-580***~~[304.17A-590]~~, unless the context requires otherwise:

(1) "Areas other than urban areas" means a classification code that does not meet the definition of urban area;

(2) "Contract holder" means an employer or organization that purchases a health benefit plan;

(3) ~~["Covered person" means a person on whose behalf an insurer offering the plan is obligated to pay benefits or provide services under the health insurance policy;~~

~~(4) "Emergency medical condition" means:~~

~~(a) A medical condition manifesting itself by acute symptoms of sufficient~~

~~severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:~~

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

~~2. Serious impairment to bodily functions; or~~

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

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

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

~~2. A situation in which transfer may pose a threat to the health or safety of the woman or the unborn child;~~

~~(5)~~ "Enrollee" means a person who is enrolled in a plan offered by a health maintenance organization as defined in KRS 304.38-030~~(5)~~;

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

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

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

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

(7) ~~(10) "Participating health care provider" means a health care provider that has~~

~~entered into an agreement with an insurer to provide health care services;~~

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

(8) [~~(12)~~] "Record" means any written, printed, or electronically recorded material maintained by a provider in the course of providing health services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence during or in connection with the provision of health services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health services to a patient;

(9) [~~(13)~~] "Risk sharing arrangement" means any agreement that allows an insurer to share the financial risk of providing health care services to enrollees or insureds with another entity or provider where there is a chance of financial loss to the entity or provider as a result of the delivery of a service. A risk sharing arrangement shall not include a reinsurance contract with an accredited or admitted reinsurer;

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

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

➔Section 19. KRS 304.17A-527 is amended to read as follows:

(1) A managed care plan shall file with the commissioner sample copies of any

agreements it enters into with providers for the provision of health care services. The commissioner shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following:

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

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

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

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

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

(c) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the

provider and the managed care plan;

(d) A clause stating that the insurer issuing a managed care plan will, upon request of a participating provider, provide or make available to a participating provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the provider to determine the manner and amount of payments under the contract for the provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577; and

(e) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) An insurer that offers a health benefit plan that enters into any risk-sharing arrangement or subcontract agreement shall file a copy of the arrangement with the commissioner. The insurer shall also file the following information regarding the risk-sharing arrangement:

(a) The number of enrollees affected by the risk-sharing arrangement;

(b) The health care services to be provided to an enrollee under the risk-sharing arrangement;

(c) The nature of the financial risk to be shared between the insurer and entity or provider, including but not limited to the method of compensation;

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to ***304.17A-580***~~[304.17A-590]~~ in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and method of review.

(3) Nothing in this section shall be construed as requiring an insurer to submit the actual financial information agreed to between the insurer and the entity or provider. The commissioner shall have access to a specific risk sharing arrangement with an entity or provider upon request to the insurer. Financial information obtained by the department shall be considered to be a trade secret and shall not be subject to KRS 61.872 to 61.884.

➔Section 20. KRS 304.17A-600 is amended to read as follows:

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

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

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

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

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

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

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

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

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" ***has the same meaning as in Section 1 of this Act, except***~~[means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under~~

~~Chapter 55 of Title 10, United States Code; or limited health service benefit plans; and~~] for purposes of KRS 304.17A-600 to 304.17A-633***, the term also*** includes short-term coverage policies;

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;

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

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

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

(11) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any

insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(12) "Prospective review" means utilization review that is conducted prior to a hospital admission or a course of treatment;

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

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

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

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

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

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(b) "Urgent care" shall include all requests for hospitalization and outpatient surgery;

(18) "Utilization review" means a review of the medical necessity and appropriateness of

hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review; and

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

➔Section 21. KRS 304.17B-001 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12) ~~[(14)]~~ "High-cost condition" means acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease, chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short gestation period for a newborn child, and low birth weight of a newborn child;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

➔Section 22. KRS 304.17B-015 is amended to read as follows:

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

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

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

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

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

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year

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

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

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

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

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

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

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

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

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

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

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

➔Section 23. KRS 304.17B-033 is amended to read as follows:

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

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

➔Section 24. KRS 304.17C-010 is amended to read as follows:

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

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

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

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

(4) "Insurer" ***has the same meaning as in Section 1 of this Act, except for purposes of this subtitle, the term also includes a***~~[means any insurance company, health maintenance organization, self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA, provider-sponsored integrated health delivery network, self-insured employer organized association, nonprofit hospital, medical-surgical, dental, health service corporation, or]~~ limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

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

➔Section 25. KRS 304.18-114 is amended to read as follows:

(1) As used in this section:

(a) "Conversion health insurance coverage" means a health benefit plan meeting the requirements of this section and regulated in accordance with Subtitles 17 and 17A of this chapter;

(b) "Group policy" has the meaning provided in KRS 304.18-110; and

(c) "Medicare" has the meaning provided in KRS 304.18-110.

(2) An insurer providing group health insurance coverage shall offer a conversion health insurance policy, by written notice, to any group member terminated under the group policy for any reason. The insurer shall offer a conversion health insurance policy substantially similar to the group policy. The former group member shall meet the following conditions:

(a) The former group member had been a member of the group and covered under any health insurance policy offered by the group for at least three (3) months;

(b) The former group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (5) of this section; and

(c) The former group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (5) of this section.

(3) An insurer shall offer the following terms of conversion health insurance coverage:

(a) Conversion health insurance coverage shall be available without evidence of insurability and may contain a pre-existing condition limitation in accordance with KRS 304.17A-230;

(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:

1. The effective date of the conversion policy; or

2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;

(c) The conversion health insurance policy shall cover the former group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated.

(d) The effective date of the conversion health insurance policy shall be the date

of termination of coverage under the group policy; and

(e) The conversion health insurance policy shall provide benefits substantially similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120 and any administrative regulations promulgated thereunder.

(4) Conversion health insurance coverage need not be granted in the following situations:

(a) On the effective date of coverage, the applicant is or could be covered by Medicare;

(b) On the effective date of coverage, the applicant is or could be covered by another group coverage (insured or uninsured) or, the applicant is covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or

(c) The issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection.

(5) Notice of the right to conversion health insurance coverage shall be given as follows:

(a) For group policies delivered, issued for delivery, or renewed after July 15, 2002, the insurer shall give written notice of the right to conversion health insurance coverage to any former group member entitled to conversion coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group, upon termination of the former group member's continued group health insurance coverage pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-

005~~[(7)]~~, or upon termination of the group policy for any reason. The written notice shall clearly explain the former group member's right to a conversion policy.

(b) The thirty-one (31) day period of subsection (2)(b) of this section shall not begin to run until the notice required by this subsection is mailed or delivered to the last known address of the former group member.

(c) If a former group member becomes entitled to obtain conversion health insurance coverage, pursuant to this section, and the insurer fails to give the former group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of conversion rights to the former group member and such former group member shall have an additional period within which to exercise his conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the former group member shall constitute the giving of notice for the purpose of this paragraph. If a former group member makes application and pays the premium, for conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage. However, nothing in this subsection shall require an insurer to give notice or provide conversion coverage to a former group member ninety (90) days after termination of the former group member's group coverage.

➔Section 26. KRS 304.38A-010 is amended to read as follows:

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

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

plan;

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

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

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

(5) "Limited health service organization" means a corporation, partnership, limited liability company, or other entity that undertakes to provide or arrange limited health service or services to enrollees. A limited health service organization does not include a provider or an entity when providing or arranging for the provision of limited health services under a contract with a limited health service organization, health maintenance organization, or a health insurer; and

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

➔Section 27. KRS 304.39-241 is amended to read as follows:

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

already paid arising from a covered loss to reimburse:

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

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

(3) Medicaid;

(4) Medicare; or

(5) A Medicare supplement provider.

➔Section 28. KRS 18A.225 (Effective July 1, 2019) is amended to read as follows:

(1) (a) The term "employee" for purposes of this section means:

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567;

2. Any certified or classified employee of a local board of education;

3. Any elected member of a local board of education;

4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, Kentucky Teachers'

Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(4)(c), unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees and retirees who are entitled to participate in the state-sponsored health insurance program;

(b) The term "health benefit plan" for the purposes of this section means a health benefit plan as defined in KRS 304.17A-005;

(c) The term "insurer" for the purposes of this section means an insurer as defined in KRS 304.17A-005; and

(d) The term "managed care plan" for the purposes of this section means a managed care plan as defined in KRS 304.17A-500.

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more insurers authorized to do business in this state, a group health benefit plan that may include but not be limited to health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of employees. With the exception of employers governed by the provisions of KRS Chapters 16, 18A, and 151B, all employers of any class of employees or former employees shall enter into a contract with the Personnel Cabinet prior to including that group in the state

health insurance group. The contracts shall include but not be limited to designating the entity responsible for filing any federal forms, adoption of policies required for proper plan administration, acceptance of the contractual provisions with health insurance carriers or third-party administrators, and adoption of the payment and reimbursement methods necessary for efficient administration of the health insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

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

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

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

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier and shall develop methods to protect the confidentiality of the individual. The Personnel Cabinet shall include in the October annual report submitted pursuant to the provisions of KRS 18A.226 to the Governor, the General Assembly, and the Chief Justice of the Supreme Court, an analysis of the financial stability of the program, which shall include but not be limited to loss ratios, methods of risk adjustment, measurements of carrier quality of service, prescription coverage and cost management, and statutorily required mandates. If state self-insurance was available as a carrier option, the report also shall provide a detailed financial analysis of the self-insurance fund including but not limited to loss ratios, reserves, and reinsurance agreements.

(f) If any agency participating in the state-sponsored employee health insurance program for its active employees terminates participation and there is a state

appropriation for the employer's contribution for active employees' health insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

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

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

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

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

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

(c) Partly from each, except that any premium due for health care coverage or dental coverage, if any, in excess of the premium amount contributed by any department, board, agency, postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government for any other health care coverage shall be paid by the employee.

(4) If an employee moves his place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he has elected coverage, into either the service area of another managed health care plan or into an area of the Commonwealth not within a managed health care plan service area, the

employee shall be given an option, at the time of the move or transfer, to change his or her coverage to another health benefit plan.

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

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

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

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

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or his designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1)

member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

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

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

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

the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.

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

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

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

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

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

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

(17) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac

catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a contiguous county that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

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

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

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

(a) The regional rating bid scenario shall not include a request for bid on a statewide option;

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

(c) The request for proposal shall require a carrier's bid to include every county

within the region or regions for which the bid is submitted and include but not be restricted to a preferred provider organization (PPO) option;

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

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

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

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

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

(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or

after July 1, 2019, to public employees pursuant to this section shall comply with KRS 304.17A-138.

➔Section 29. The following KRS sections are repealed:

304.17A-590 Participating provider directories.

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

304.17A-641 Treatment of a stabilized covered person with an emergency medical condition in a nonparticipating hospital's emergency room.

304.17A-645 Covered person's access to participating nonprimary care physician specialist.

304.17A-647 Covered person's access to participating obstetrician or gynecologist -- Authorization for annual pap smear without referral.

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

➔Section 30. This Act may be known as the Out-of-Network Balance Billing Transparency Act.

➔Section 31. This Act takes effect January 1, 2020.