AN ACT relating to prior authorization.

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

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

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

(2) Unless otherwise prohibited by state or federal law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug has not been deemed unsafe by the United States Food and Drug Administration, or withdrawn by the manufacturer or the United States Food and Drug Administration, the prior authorization received shall be valid for the lessor of:

(a) One (1) year from the date the provider receives the prior authorization; or

(b) Until the last day of coverage under the covered person's health benefit plan during a single plan year.

➔Section 2. KRS 205.522 (Effective January 1, 2019) is amended to read as follows:

The Department for Medicaid Services and any managed care organization contracted to provide ~~[a managed care organization that provides]~~ Medicaid benefits pursuant to this chapter shall comply with the provisions of KRS 304.17A-235, 304.17A-515, ~~[and]~~

304.17A-740 to 304.17A-743***, Section 1 and Sections 6, 7, 8 and 9 of this Act***.

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

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

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

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

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

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

(5) ~~[Within twenty-four (24) months of the National Council for Prescription Drug Programs developing and making available national standards for electronic prior authorization,]~~Each governmental unit of the Commonwealth promulgating administrative regulations relating to electronic prescribing ***shall include in the regulations*** ~~[shall consider such electronic prescribing and]~~ electronic prior authorization standards ***meeting the requirements of Section 1 of this Act*** in its implementation of health information technology improvements as required by the

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

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

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

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

(3) Drug information contained in electronic prescribing software to prescribe a controlled substance under this chapter shall be consistent with Food and Drug Administration-approved information regarding a particular controlled substance.

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

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

(5) ~~[Within twenty-four (24) months of the National Council for Prescription Drug Programs developing and making available national standards for electronic prior authorization,]~~Each governmental unit of the Commonwealth promulgating administrative regulations relating to electronic prescribing ***shall include in the regulations***~~[shall consider such electronic prescribing and]~~ electronic prior

authorization standards ***meeting the requirements of Section 1 of this Act*** in its implementation of health information technology improvements as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

➔Section 5. KRS 304.17A-005 (Effective until 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) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist.

Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

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

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

(7) "COBRA" means any of the following:

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

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

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

(8) (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;

(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;

(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;

(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;

(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" ***as defined 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;

(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;

(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;

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

(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;

(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;

(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;

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

(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;

(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;

(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, 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;

(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 to 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;

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

(b) The term includes the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

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

(26) ~~[(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;

(27) ~~[(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;

(28) ~~[(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;

(29) ~~[(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;

(30) ~~[(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;

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

(32) ~~[(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;

(33) ~~[(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;

(34) ~~[(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;

(35) "Medically necessary health care services" means health care services that a

prudent provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, and duration; and

(c) In no part for the economic benefit of the insurer or private review agent, as defined in Section 7 of this Act or for the convenience of the covered person or provider;

(36) ~~[(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;

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

(38) ~~[(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;

(39) ~~[(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;

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

(41) ~~[(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;

(42) ~~[(39)]~~ "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have

entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(43) ~~[(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;

(44) ~~[(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;

(45) ~~[(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;

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

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

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

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

(2) An insurer offering health benefit plans shall cover emergency medical conditions and shall pay for emergency department screening and stabilization services 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. ***For all screening and stabilization services provided to a covered person by an emergency department,*** an insurer shall be prohibited from***:*** ~~[.]~~

(a) Denying the emergency ***department***~~[room]~~ services***;*** ~~[and]~~

(b) Altering the level of coverage or cost-sharing requirements***; or***

(c) Requiring a concurrent or retrospective review, as defined in Section 7 of this Act~~[for any condition or conditions that constitute an emergency medical condition as defined in KRS 304.17A-500]~~.

(3) ***Screening and stabilization services required to be covered by subsection (2) of this section shall be deemed to be medically necessary.***

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

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

➔Section 7. 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 KRS 304.17A-005, except that***~~[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*** 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 ***a*** utilization review that is conducted prior to ***the provision of health care services.*** ~~[a hospital admission or a course of treatment]~~ ***"Prospective review" also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy, preadmission review, pretreatment review, utilization, and case management***;

(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;

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

(15) ~~[(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;

(16) ~~[(17)]~~ (a) "Urgent ***health*** care ***services***" 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 ***health*** care ***services***" shall include all requests for hospitalization and outpatient surgery;

(17) ~~[(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

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

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

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

(2) An insurer shall maintain written procedures for:

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

(b) ~~[(2)]~~ Making utilization review determinations; and

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

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

(b) Written procedures, including any changes to existing procedures, required by this section shall only be enforceable by an insurer under a health benefit plan if the insurer updates its Web site within thirty (30) days of the proposed effective date to reflect those procedures.

➔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***, for any contract entered into on or after the effective date of this Act for the provision of utilization review services,*** only licensed physicians***, who are of the same specialty and subspecialty, when possible, as the ordering provider*** 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) 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, ***or as otherwise provided in this section,*** provide a utilization review decision ~~[relating to urgent and nonurgent care]~~in accordance with ***the timeframes in paragraph (i) of this subsection and*** 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 such notices electronically and shall include the required elements of subsection (j) of this section]~~;

(i) ***1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and***

2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within seventy-two (72) hours of obtaining all necessary information to make the utilization review decision.

For purposes of this paragraph, "necessary information" is limited to:

a. The results of any face-to-face clinical evaluation;

b. Any second opinion that may be required; and

c. Any other information determined by the department to be necessary to making a utilization review determination~~[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) Provide written notice of review decisions to the covered person, authorized person, and providers. ***The written notice may be provided in an electronic format, including e-mail or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically.*** An insurer or agent that denies ***step therapy, as defined in KRS 304.17A-163, overrides or denies*** coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

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

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

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, 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;

(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 ***or private review agent's*** failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be ***a prior authorization for the health care services or benefits subject to the review***~~[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-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 11. This Act takes effect January 1, 2020.