

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

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

3 ➔Section 1. KRS 304.17A-005 is amended to read as follows:

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

- 5 (1) "Association" means an entity, other than an employer-organized association, that  
6 has been organized and is maintained in good faith for purposes other than that of  
7 obtaining insurance for its members and that has a constitution and bylaws;
- 8 (2) "At the time of enrollment" means:  
9 (a) At the time of application for an individual, an association that actively  
10 markets to individual members, and an employer-organized association that  
11 actively markets to individual members; and  
12 (b) During the time of open enrollment or during an insured's initial or special  
13 enrollment periods for group health insurance;
- 14 (3) "Base premium rate" means, for each class of business as to a rating period, the  
15 lowest premium rate charged or that could have been charged under the rating  
16 system for that class of business by the insurer to the individual or small group, or  
17 employer as defined in KRS 304.17A-0954, with similar case characteristics for  
18 health benefit plans with the same or similar coverage;
- 19 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,  
20 or employer-organized association that limits coverage to physician, pharmacy,  
21 home health, preventive, emergency, and inpatient and outpatient hospital services  
22 in accordance with the requirements of this subtitle. If vision or eye services are  
23 offered, these services may be provided by an ophthalmologist or optometrist.  
24 Chiropractic benefits may be offered by providers licensed pursuant to KRS  
25 Chapter 312;
- 26 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-  
27 91(d)(3);

- 1 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
- 2 (7) "COBRA" means any of the following:
- 3 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
- 4 vaccines;
- 5 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
- 6 et seq. other than sec. 1169); or
- 7 (c) 42 U.S.C. sec. 300bb;
- 8 **(8) "Cost-sharing":**
- 9 **(a) Means any expenditure required under a health insurance policy or plan to**
- 10 **be paid by or on behalf of an insured with respect to receiving plan benefits;**
- 11 **(b) Includes coinsurance, copayments, and deductibles; and**
- 12 **(c) Does not include premiums, balance billing amounts for out-of-network**
- 13 **providers, or spending for noncovered services;**
- 14 **(9)[(8)]** "Creditable coverage":
- 15 (a) Means, with respect to an individual, coverage of the individual under any of
- 16 the following:
- 17 1. A group health plan;
- 18 2. Health insurance coverage;
- 19 3. Part A or Part B of Title XVIII of the Social Security Act;
- 20 4. Title XIX of the Social Security Act, other than coverage consisting
- 21 solely of benefits under section 1928;
- 22 5. Chapter 55 of Title 10, United States Code, including medical and dental
- 23 care for members and certain former members of the uniformed services,
- 24 and for their dependents; for purposes of Chapter 55 of Title 10, United
- 25 States Code, "uniformed services" means the Armed Forces and the
- 26 Commissioned Corps of the National Oceanic and Atmospheric
- 27 Administration and of the Public Health Service;

- 1           6. A medical care program of the Indian Health Service or of a tribal  
2           organization;
- 3           7. A state health benefits risk pool;
- 4           8. A health plan offered under Chapter 89 of Title 5, United States Code,  
5           such as the Federal Employees Health Benefit Program;
- 6           9. A public health plan as established or maintained by a state, the United  
7           States government, a foreign country, or any political subdivision of a  
8           state, the United States government, or a foreign country that provides  
9           health coverage to individuals who are enrolled in the plan;
- 10          10. A health benefit plan under section 5(e) of the Peace Corps Act (22  
11          U.S.C. sec. 2504(e)); or
- 12          11. Title XXI of the Social Security Act, such as the State Children's Health  
13          Insurance Program; and
- 14          (b) Does not include coverage consisting solely of coverage of excepted benefits  
15          as defined in this section;

16       ~~(10)~~<sup>(9)</sup> "Dependent" means any individual who is or may become eligible for  
17       coverage under the terms of an individual or group health benefit plan because of a  
18       relationship to a participant;

19       **(11) "Emergency medical condition" means:**

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

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

27       **2. Serious impairment to bodily functions; or**

1                    **3. Serious dysfunction of any bodily functions; or**

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

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

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

7                    **(12)**~~(10)~~ "Employee benefit plan" means an employee welfare benefit plan or an  
8                    employee pension benefit plan or a plan which is both an employee welfare benefit  
9                    plan and an employee pension benefit plan as defined by ERISA;

10                   **(13)**~~(11)~~ "Eligible individual" means an individual:

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

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

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

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

1 coverage; and

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

4 ~~(14)~~~~(12)~~ "Employer-organized association" means any of the following:

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

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

11 (c) Any entity or association of employers, which has been actively in existence  
12 for at least two (2) years, formed under the Employee Retirement Income  
13 Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare  
14 benefit plan under guidance issued by the United States Department of Labor  
15 prior to the issuance of 29 C.F.R. sec. 2510.3-5, and for which the entity's  
16 health insurance decisions are made by a board or committee, the majority of  
17 which are representatives of employer members of the entity who obtain  
18 group health insurance coverage through the entity or through a trust or other  
19 mechanism established by the entity, and whose health insurance decisions are  
20 reflected in written minutes or other written documentation; and

21 (d) Any entity or association of employers, which has been actively in existence  
22 for at least two (2) years, formed under the Employee Retirement Income  
23 Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare  
24 benefit plan, whose members consist of employers or a group of employers  
25 that satisfy the requirements of 29 C.F.R. sec. 2510.3-5.

26 Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and  
27 except as otherwise provided by the definition of "large group" contained in this

1 section, an employer-organized association shall not be treated as an association,  
2 small group, or large group under this subtitle, except that an employer-organized  
3 association as defined under paragraph (c) or (d) of this subsection shall be treated  
4 as a large group under this subtitle;

5 ~~(15)~~~~(13)~~ "Employer-organized association health insurance plan" means any health  
6 insurance plan, policy, or contract issued to an employer-organized association, or  
7 to a trust established by one (1) or more employer-organized associations, or  
8 providing coverage solely for the employees, retired employees, directors and their  
9 spouses and dependents of the members of one (1) or more employer-organized  
10 associations;

11 ~~(16)~~~~(14)~~ "Excepted benefits" means benefits under one (1) or more, or any combination  
12 of the following:

- 13 (a) Coverage only for accident, including accidental death and dismemberment,  
14 or disability income insurance, or any combination thereof;
- 15 (b) Coverage issued as a supplement to liability insurance;
- 16 (c) Liability insurance, including general liability insurance and automobile  
17 liability insurance;
- 18 (d) Workers' compensation or similar insurance;
- 19 (e) Automobile medical payment insurance;
- 20 (f) Credit-only insurance;
- 21 (g) Coverage for on-site medical clinics;
- 22 (h) Other similar insurance coverage, specified in administrative regulations,  
23 under which benefits for medical care are secondary or incidental to other  
24 insurance benefits;
- 25 (i) Limited scope dental or vision benefits;
- 26 (j) Benefits for long-term care, nursing home care, home health care, community-  
27 based care, or any combination thereof;

- 1 (k) Such other similar, limited benefits as are specified in administrative  
2 regulations;
- 3 (l) Coverage only for a specified disease or illness;
- 4 (m) Hospital indemnity or other fixed indemnity insurance;
- 5 (n) Benefits offered as Medicare supplemental health insurance, as defined under  
6 section 1882(g)(1) of the Social Security Act;
- 7 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,  
8 United States Code;
- 9 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is  
10 supplemental to coverage under a group health plan; and
- 11 (q) Health flexible spending arrangements;
- 12 ~~(17)~~~~(15)~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.  
13 1002(32);
- 14 ~~(18)~~~~(16)~~ "Group health plan" means a plan, including a self-insured plan, of or  
15 contributed to by an employer, including a self-employed person, or employee  
16 organization, to provide health care directly or otherwise to the employees, former  
17 employees, the employer, or others associated or formerly associated with the  
18 employer in a business relationship, or their families;
- 19 ~~(19)~~~~(17)~~ "Guaranteed acceptance program participating insurer" means an insurer that  
20 is required to or has agreed to offer health benefit plans in the individual market to  
21 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to  
22 304.17A-480;
- 23 ~~(20)~~~~(18)~~ "Guaranteed acceptance program plan" means a health benefit plan in the  
24 individual market issued by an insurer that provides health benefits to a guaranteed  
25 acceptance program qualified individual and is eligible for assessment and refunds  
26 under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
- 27 ~~(21)~~~~(19)~~ "Guaranteed acceptance program" means the Kentucky Guaranteed

1 Acceptance Program established and operated under KRS 304.17A-400 to  
2 304.17A-480;

3 ~~(22)~~~~(20)~~ "Guaranteed acceptance program qualified individual" means an individual  
4 who, on or before December 31, 2000:

5 (a) Is not an eligible individual;

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

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

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

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

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

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

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

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

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



1 ~~(23)~~~~(21)~~ "Guaranteed acceptance plan supporting insurer" means either an insurer, on  
2 or before December 31, 2000, that is not a guaranteed acceptance plan participating  
3 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a  
4 guaranteed acceptance plan supporting insurer shall not include an employer-  
5 sponsored self-insured health benefit plan exempted by ERISA;

6 ~~(24)~~~~(22)~~ "Health benefit plan":

7 (a) Shall include any:

- 8 1. Hospital or medical expense policy or certificate;
- 9 2. Nonprofit hospital, medical-surgical, and health service corporation  
10 contract or certificate;
- 11 3. Provider sponsored integrated health delivery network;
- 12 4. Self-insured plan or a plan provided by a multiple employer welfare  
13 arrangement, to the extent permitted by ERISA;
- 14 5. Self-insured governmental plan or church plan;
- 15 6. Health maintenance organization contract, except contracts to provide  
16 Medicaid benefits under KRS Chapter 205; or
- 17 7. Health benefit plan that affects the rights of a Kentucky insured and  
18 bears a reasonable relation to Kentucky, whether delivered or issued for  
19 delivery in Kentucky; and

20 (b) Does not include:

- 21 1. Policies covering only accident, credit, dental, disability income, fixed  
22 indemnity medical expense reimbursement, long-term care, Medicare  
23 supplement, specified disease, or vision care;
- 24 2. Coverage issued as a supplement to liability insurance;
- 25 3. Insurance arising out of a workers' compensation or similar law;
- 26 4. Automobile medical-payment insurance;
- 27 5. Insurance under which benefits are payable with or without regard to

- 1 fault and that is statutorily required to be contained in any liability  
2 insurance policy or equivalent self-insurance;
- 3 6. Short-term limited-duration coverage;
- 4 7. Student health insurance offered by a Kentucky-licensed insurer under  
5 written contract with a university or college whose students it proposes  
6 to insure;
- 7 8. Medical expense reimbursement policies specifically designed to fill  
8 gaps in primary coverage, coinsurance, or deductibles and provided  
9 under a separate policy, certificate, or contract;
- 10 9. Coverage supplemental to the coverage provided under Chapter 55 of  
11 Title 10, United States Code;
- 12 10. Limited health service benefit plans;
- 13 11. Direct primary care agreements established under KRS 311.6201,  
14 311.6202, 314.198, and 314.199; or
- 15 12. Coverage provided under KRS Chapter 205;
- 16 ~~(25)~~~~(23)~~ "Health care provider" or "provider" means any:
- 17 (a) Advanced practice registered nurse licensed under KRS Chapter 314;
- 18 (b) Chiropractor licensed under KRS Chapter 312;
- 19 (c) Dentist licensed under KRS Chapter 313;
- 20 (d) Facility or service required to be licensed under KRS Chapter 216B;
- 21 (e) Home medical equipment and services provider licensed under KRS Chapter  
22 309;
- 23 (f) Optometrist licensed under KRS Chapter 320;
- 24 (g) Pharmacist licensed under KRS Chapter 315;
- 25 (h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;
- 26 (i) Physician assistant regulated under KRS Chapter 311; and
- 27 (j) Other health care practitioners as determined by the department by

1 administrative regulations promulgated under KRS Chapter 13A;

2 ~~(26)~~~~(24)~~ (a) "Health care service" means health care procedures, treatments, or  
3 services rendered by a provider within the scope of practice for which the  
4 provider is licensed.

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

7 ~~(27)~~~~(25)~~ "Health facility" or "facility" has the same meaning as in KRS 216B.015;

8 ~~(28)~~~~(26)~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance  
9 Program, means a covered condition in an individual policy as listed in  
10 paragraph (c) of this subsection or as added by the commissioner in  
11 accordance with KRS 304.17A-280, but only to the extent that the condition  
12 exceeds the numerical score or rating established pursuant to uniform  
13 underwriting standards prescribed by the commissioner under paragraph (b) of  
14 this subsection that account for the severity of the condition and the cost  
15 associated with treating that condition.

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

19 1. Codes in the most recent version of the "International Classification of  
20 Diseases" that correspond to the medical conditions in paragraph (c) of  
21 this subsection and the costs for administering treatment for the  
22 conditions represented by those codes; and

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

27 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome

1 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,  
2 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,  
3 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,  
4 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,  
5 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,  
6 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,  
7 stroke, syringomyelia, Wilson's disease, and amyotrophic lateral sclerosis;

8 (29)~~[(27)]~~ "Index rate" means, for each class of business as to a rating period, the  
9 arithmetic average of the applicable base premium rate and the corresponding  
10 highest premium rate;

11 (30)~~[(28)]~~ "Individual market" means the market for the health insurance coverage  
12 offered to individuals other than in connection with a group health plan. The  
13 individual market includes an association plan that is not employer-related, issued  
14 to individuals on an individually underwritten basis, other than an employer-  
15 organized association or a bona fide association;

16 (31)~~[(29)]~~ "Insurer" means any insurance company; health maintenance organization;  
17 self-insurer, including a governmental plan, church plan, or multiple employer  
18 welfare arrangement, not exempt from state regulation by ERISA; provider-  
19 sponsored integrated health delivery network; self-insured employer-organized  
20 association, or nonprofit hospital, medical-surgical, dental, or health service  
21 corporation authorized to transact health insurance business in Kentucky;

22 (32)~~[(30)]~~ "Insurer-controlled" means that the commissioner has found, in an  
23 administrative hearing called specifically for that purpose, that an insurer has or had  
24 a substantial involvement in the organization or day-to-day operation of the entity  
25 for the principal purpose of creating a device, arrangement, or scheme by which the  
26 insurer segments employer groups according to their actual or anticipated health  
27 status or actual or projected health insurance premiums;

1 ~~(33)~~~~(31)~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001;

2 ~~(34)~~~~(32)~~ "Large group" means:

- 3 (a) An employer with fifty-one (51) or more employees;
- 4 (b) An affiliated group with fifty-one (51) or more eligible members; or
- 5 (c) A fully insured employer-organized association as defined in subsection
- 6 ~~(14)~~~~(12)~~(c) or (d) of this section that:
- 7 1. Covers at least fifty-one (51) employee members; and
- 8 2. Is registered with the department pursuant to administrative regulations
- 9 promulgated by the commissioner;

10 ~~(35)~~~~(33)~~ "Managed care" means systems or techniques generally used by third-party

11 payors or their agents to affect access to and control payment for health care

12 services and that integrate the financing and delivery of appropriate health care

13 services to covered persons by arrangements with participating providers who are

14 selected to participate on the basis of explicit standards for furnishing a

15 comprehensive set of health care services and financial incentives for covered

16 persons using the participating providers and procedures provided for in the plan;

17 ~~(36)~~~~(34)~~ "Market segment" means the portion of the market covering one (1) of the

18 following:

- 19 (a) Individual;
- 20 (b) Small group;
- 21 (c) Large group; or
- 22 (d) Association;

23 ~~(37)~~~~(35)~~ "Medically necessary health care services" means health care services that a

24 provider would render to a patient for the purpose of preventing, diagnosing, or

25 treating an illness, injury, disease, or its symptoms in a manner that is:

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

1 **(38) "Nonparticipating health care provider" or "nonparticipating provider" means a**  
2 **provider that has not entered into an agreement with an insurer to provide health**  
3 **care services to its insureds;**

4 **(39)**~~(36)~~ "Participant" means any employee or former employee of an employer, or any  
5 member or former member of an employee organization, who is or may become  
6 eligible to receive a benefit of any type from an employee benefit plan which covers  
7 employees of the employer or members of the organization, or whose beneficiaries  
8 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

9 **(40) "Participating health care provider" or "participating provider" means a**  
10 **provider that has entered into an agreement with an insurer to provide health**  
11 **care services to its insureds;**

12 **(41)**~~(37)~~ "Preventive services" means medical services for the early detection of disease  
13 that are associated with substantial reduction in morbidity and mortality;

14 **(42)**~~(38)~~ "Provider network" means an affiliated group of varied health care providers  
15 that is established to provide a continuum of health care services to individuals;

16 **(43)**~~(39)~~ "Provider-sponsored integrated health delivery network" means any provider-  
17 sponsored integrated health delivery network created and qualified under KRS  
18 304.17A-300 and KRS 304.17A-310;

19 **(44)**~~(40)~~ "Purchaser" means an individual, organization, employer, association, or the  
20 Commonwealth that makes health benefit purchasing decisions on behalf of a group  
21 of individuals;

22 **(45)**~~(41)~~ "Rating period" means the calendar period for which premium rates are in  
23 effect. A rating period shall not be required to be a calendar year;

24 **(46)**~~(42)~~ "Restricted provider network" means a health benefit plan that conditions the  
25 payment of benefits, in whole or in part, on the use of the providers that have  
26 entered into a contractual arrangement with the insurer to provide health care  
27 services to covered individuals;

1 ~~(47)~~~~((43))~~ "Self-insured plan" means a group health insurance plan in which the  
2 sponsoring organization assumes the financial risk of paying for covered services  
3 provided to its enrollees;

4 ~~(48)~~~~((44))~~ "Small employer" means, in connection with a group health plan with respect  
5 to a calendar year and a plan year, an employer who employed an average of at least  
6 two (2) but not more than fifty (50) employees on business days during the  
7 preceding calendar year and who employs at least two (2) employees on the first day  
8 of the plan year;

9 ~~(49)~~~~((45))~~ "Small group" means:

- 10 (a) A small employer with two (2) to fifty (50) employees; or  
11 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

12 ~~(50)~~~~((46))~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

13 ~~(51)~~~~((47))~~ "Telehealth":

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

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

25 (c) Shall be delivered over a secure communications connection that complies  
26 with the federal Health Insurance Portability and Accountability Act of 1996,  
27 42 U.S.C. secs. 1320d to 1320d-9.

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

3 **(1) The commissioner shall promulgate administrative regulations to:**

4           **(a) Specify a nonprofit organization that maintains a database of billed charges**  
5           **submitted by providers for health care services to be used as a benchmark**  
6           **for determining the usual and customary rate under Section 4 of this Act.**  
7           **The nonprofit shall not be affiliated with an insurer offering health benefit**  
8           **plans in Kentucky; and**

9           **(b) Require all insurers to submit to the department annually no later than**  
10           **March 1 of each year, all billed charges received from both participating**  
11           **and nonparticipating providers for each health care service.**

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

13           **(a) Be reported on a form and in a manner determined by the department;**

14           **(b) Not include any personally identifying information of an insured; and**

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

16 **(3) The department shall provide information reported pursuant to this section to the**  
17 **nonprofit identified in subsection (1) of this section, or if no nonprofit exists**  
18 **meeting the requirements of subsection (1) of this section, then the department**  
19 **shall publish this information in a report on its Web site by June 1 of each year.**

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

22 **(1) As used in this section:**

23           **(a) "Balance bill" or "balance billing" refers to a provider billing an insured**  
24           **for the remaining balance of the amount a provider charges for a service**  
25           **less the following:**

26           **1. The amount an insurer reimburses; and**

27           **2. Any applicable cost-sharing the insured is required to pay;**



1 (b) "Covered health care services" means:

2 1. Health care services that are covered under an insured's health  
3 benefit plan; or

4 2. Noncovered health care services that would otherwise be covered  
5 under the insured's health benefit plan if the services were provided by  
6 a participating provider;

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

10 (d) "Insured" means a person covered under a health benefit plan; and

11 (e) "Unanticipated out-of-network care":

12 1. Means covered health care services received by an insured in a health  
13 facility from a nonparticipating provider when the insured did not  
14 have the ability to direct that the services be provided by a  
15 participating provider, including out-of-network emergency health  
16 care services; and

17 2. Does not include nonemergency health care services, if the insured  
18 voluntarily selects in writing a nonparticipating provider prior to the  
19 provision of services.

20 (2) A nonparticipating provider shall send a bill for unanticipated out-of-network  
21 care to the insured's insurer. The insurer shall:

22 (a) Within thirty (30) days of receiving a bill for unanticipated out-of-network  
23 care, reimburse the nonparticipating provider at the greater of the  
24 following, less any cost-sharing owed by the insured:

25 1. The insurer's median in-network rate for the current year; or

26 2. The insurer's median in-network rate for the year 2018; and

27 (b) Send a notice to the nonparticipating provider of any cost-sharing owed

- 1           under the insured's health benefit plan for the unanticipated out-of-network  
2           care. The amount of cost-sharing owed shall:
- 3           1. Not exceed the amount of cost-sharing that would have been owed if  
4           the services were provided by a participating provider; and
- 5           2. Be calculated based on the reimbursement amount determined under  
6           this section.
- 7   (3) A nonparticipating provider who has been reimbursed by an insurer under  
8   subsection (2) of this section:
- 9           (a) Shall not balance bill an insured; and  
10          (b) May bill an insured for any applicable cost-sharing.
- 11   (4) (a) Any cost-sharing that the insured pays under this section shall be  
12    attributable to any annual deductibles and out-of-pocket maximums  
13    required under the terms of the insured's health benefit plan.
- 14          (b) The entire amount paid by the insured to the nonparticipating provider  
15    shall be attributable to any annual deductible and out-of-pocket maximums  
16    required under the terms of the insured's health benefit plan when an  
17    insurer does not make a reimbursement under this section because the cost-  
18    sharing owed for the unanticipated out-of-network care is more than the  
19    reimbursement amount determined under this section.
- 20   (5) A nonparticipating provider shall accept the reimbursement made under  
21    subsection (2) of this section, plus any applicable cost-sharing owed by an  
22    insured, as the full and final payment for the unanticipated out-of-network care,  
23    except as provided in Section 4 of this Act.
- 24   (6) An appropriate regulatory agency or board that licenses, certifies, or otherwise  
25    authorizes a provider to provide health care services in this state may take any  
26    disciplinary action that the board or agency is authorized to take against  
27    regulated providers under the agency's or board's authorizing statutes against a

1        provider that violates this section.

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

4        (1) As used in this section:

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

9            (b) "Unanticipated out-of-network care" has the same meaning as in Section 3  
10           of this Act.

11        (2) The commissioner shall:

12           (a) Establish and administer:

13                1. An independent dispute resolution program in accordance with this  
14                section; and

15                2. An application process for qualifying reviewers for the independent  
16                dispute resolution program. To be eligible as a qualified reviewer, an  
17                individual shall:

18                    a. Demonstrate knowledge of and experience in applicable  
19                    principles of contract and insurance law and the healthcare  
20                    industry generally; and

21                    b. Not have a conflict of interest that would adversely impact the  
22                    individual's independence or impartiality, including but not  
23                    limited to current or recent ownership or employment of the  
24                    individual, or a close family member, in any insurer issuing  
25                    health benefit plans, administrator of health benefit plans, or  
26                    health care provider; and

27           (b) Maintain:

- 1           1. A portal on the department's Web site through which a request for  
2                                   independent dispute resolution may be made;
- 3           2. A list of qualified reviewers for the independent dispute resolution  
4                                   program; and
- 5           3. Records of the information reported under subsection (11) of this  
6                                   section.

7   (3) (a) A nonparticipating provider may elect to dispute the reimbursement  
8                                   provided under Section 3 of this Act if:

- 9           1. The cumulative amount of charges for the unanticipated out-of-  
10                                   network care is six hundred seventy-five dollars (\$675) or more; and
- 11           2. Within thirty (30) days of the insurer's reimbursement under Section 3  
12                                   of this Act, the nonparticipating provider requests an independent  
13                                   dispute resolution proceeding by submitting a request through the  
14                                   portal on the department's Web site.

15           (b) A nonparticipating provider may submit up to ten (10) charges to be  
16                                   reviewed in a single independent dispute resolution proceeding when:

- 17           1. The reimbursements for the charges are received by the  
18                                   nonparticipating provider within the same thirty (30) day period; and
- 19           2. The charges are for a similar medical service or procedure.

20   (4) If a nonparticipating provider makes a request for an independent dispute  
21                                   resolution proceeding in accordance with subsection (3) of this section:

22           (a) Both the nonparticipating provider and the insurer shall participate in the  
23                                   proceeding; and

24           (b) On the date the request is made, the nonparticipating provider shall provide  
25                                   written notice, which shall include transmissions via e-mail or facsimile, of  
26                                   the request, in a form and manner prescribed by the commissioner, to:

- 27           1. The commissioner; and

1           2. The insurer.

2     (5) (a) The parties may select a reviewer for the independent dispute resolution  
3           proceeding by agreement. If a selection is made under this paragraph, the  
4           nonparticipating provider shall notify the commissioner of the selection  
5           within twenty (20) days of the request for an independent dispute resolution  
6           proceeding.

7           (b) If the commissioner has not received notification that the parties have  
8           selected a reviewer within twenty (20) days, the commissioner shall, within  
9           ten (10) days, select a qualified reviewer from his or her list of qualified  
10           reviewers established under subsection (2) of this section.

11           (c) The reviewer's fees shall be split evenly and paid by the insurer and the  
12           nonparticipating provider.

13     (6) (a) Within thirty (30) days from the date of the request for an independent  
14           dispute resolution proceeding, the parties shall participate in an informal  
15           settlement conference to attempt to settle the dispute. The reviewer shall not  
16           participate in the informal settlement conference.

17           (b) The nonparticipating provider shall notify the commissioner whether the  
18           parties reached a settlement within five (5) days of completion of the  
19           conference.

20     (7) The parties shall not be entitled to engage in discovery in connection with the  
21           independent dispute resolution proceeding.

22     (8) The reviewer shall:

23           (a) Set a date for the submission of all information to be considered by the  
24           reviewer;

25           (b) Except as provided in subsection (11) of this section, hold in strict  
26           confidence all information provided by a party and all communications of  
27           the reviewer with the parties; and

1 (c) Not later than sixty (60) days after the date the independent dispute  
2 resolution proceeding was requested, provide the parties with a written  
3 decision that:

4 1. Determines the reasonable amount owed to the nonparticipating  
5 provider for the unanticipated out-of-network care; and

6 2. Selects, as the amount awarded under this section, the following  
7 amount which is closest to the amount determined under  
8 subparagraph 1. of this paragraph:

9 a. The amount billed to the insurer by the nonparticipating  
10 provider; or

11 b. The amount reimbursed by the insurer under Section 3 of this  
12 Act.

13 (9) The reviewer's determination under subsection (8)(c)1. of this section shall take  
14 into account:

15 (a) Whether there is a gross disparity between the charges billed by the  
16 nonparticipating provider and:

17 1. Reimbursements paid to the nonparticipating provider for the same  
18 service rendered by the provider to other insureds for which the  
19 provider is a nonparticipating provider; and

20 2. Reimbursements paid by the insurer to reimburse similarly qualified  
21 nonparticipating providers for the same health care services in the  
22 same region;

23 (b) The level of training, education, and experience of the nonparticipating  
24 provider;

25 (c) The nonparticipating provider's historical data for billing charges for  
26 comparable services with regard to other insureds;

27 (d) The circumstance and complexity of an insured's particular case, including

- 1           the time and place of the provision of service;
- 2           (e) An individual insured's medical conditions, co-morbidities, and other
- 3           medical characteristics;
- 4           (f) The usual and customary rate of the health care service provided;
- 5           (g) The history of network contracting between the parties; and
- 6           (h) Historical data for the usual and customary rate of the health care service
- 7           provided.
- 8           (10) Except as provided in subsection (13) of this section, any deadline under this
- 9           section may be extended by agreement of the parties.
- 10          (11) A reviewer shall provide a report to the commissioner, in a form and manner
- 11          prescribed by the commissioner, that sets forth:
- 12          (a) The amount determined by the reviewer to be the reasonable amount owed
- 13          to the nonparticipating provider for the unanticipated out-of-network care;
- 14          and
- 15          (b) The amount awarded under this section.
- 16          (12) Not later than thirty (30) days after the date of the reviewer's decision, an insurer
- 17          shall pay the nonparticipating provider any amount necessary to satisfy the
- 18          amount awarded under this section.
- 19          (13) Within forty-five (45) days of a reviewer's decision under this section, a party may
- 20          file a civil action to determine the amount owed, if any, by the insurer to the
- 21          nonparticipating provider for unanticipated out-of-network care under Section 3
- 22          of this Act.
- 23          (14) Information submitted by the parties to the reviewer shall not be subject to public
- 24          disclosure under KRS 61.800 to 61.878.
- 25          (15) Nothing in this section shall be construed to limit the admissibility, in any civil
- 26          action, of the reviewer's determination or the information provided during the
- 27          independent dispute resolution process.

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

3 (1) Any health plan or health plan sponsor not otherwise required to comply with  
4 Section 2 of this Act may elect, on an annual basis, to submit to the department  
5 all billed charges received from both participating and nonparticipating providers  
6 for each health care service.

7 (2) Any health plan or health plan sponsor not otherwise required to comply with  
8 Sections 3 and 4 of this Act may elect, on an annual basis, for Sections 3 and 4 of  
9 this Act to apply to the plan.

10 (3) A health plan or health plan sponsor making one (1) or more elections under this  
11 section shall provide written notice of each election to the commissioner, in the  
12 form and manner prescribed by the commissioner.

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

15 (1) An insurer shall provide written notice of any claim made for unanticipated out-  
16 of-network care, as defined in Section 3 of this Act, in an explanation of benefits,  
17 provided to an insured and the nonparticipating provider, which shall include:

18 (a) A statement of the balance billing prohibition in Section 3 of this Act;

19 (b) The total amount the nonparticipating provider may bill the insured under  
20 Section 3 of this Act, and an itemization of cost-sharing included in that  
21 total; and

22 (c) For an explanation of benefits provided to a nonparticipating provider,  
23 information, as prescribed by the commissioner, relating to the provider's  
24 rights under Section 4 of this Act.

25 (2) The insurer shall provide the explanation of benefits, with the notices required  
26 under this section not later than the date an insurer makes a reimbursement  
27 under Section 3 of this Act.



1           ➔Section 7. KRS 304.17A-254 is amended to read as follows:

2           An insurer that offers a health benefit plan that is not a managed care plan, *as defined in*  
3           *Section 13 of this Act*, but provides financial incentives for a covered person to access a  
4           network of providers shall:

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

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

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

16           (2) Assure that contracts with the providers in the network contain a hold harmless  
17           agreement under which the covered person will not be balanced billed by the in-  
18           network provider except for deductibles, co-pays, coinsurance amounts, and  
19           noncovered benefits;

20           (3) File with the department a copy of the directory required under subsection (1) of  
21           this section;

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

- 1 (5) Not contract with a health care provider to limit the provider's disclosure to a  
2 covered person, or to another person on behalf of a covered person, of any  
3 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  
5 with the insurer, because the provider discusses medically necessary or appropriate  
6 care with a covered person or another person on behalf of a covered person. The  
7 health care provider may:
- 8 (a) Not be prohibited by the insurer from discussing all treatment options with the  
9 covered person; and
- 10 (b) Disclose to the covered person or to another person on behalf of a covered  
11 person other information determined by the health care provider to be in the  
12 best interests of the covered person;
- 13 (7) Include in any agreements it enters into with providers for the provision of health  
14 care services a clause stating that the insurer will, upon request of a health care  
15 provider, provide or make available to a health care provider, when contracting or  
16 renewing an existing contract with such provider, the payment or fee schedules or  
17 other information sufficient to enable the health care provider to determine the  
18 manner and amount of payments under the contract for the health care provider's  
19 services prior to the final execution or renewal of the contract and shall provide any  
20 change in such schedules at least ninety (90) days prior to the effective date of the  
21 amendment pursuant to KRS 304.17A-577;
- 22 (8) Establish a policy governing the removal of and withdrawal by health care providers  
23 from the provider network that includes the following:
- 24 (a) The insurer shall inform a participating health care provider of the insurer's  
25 removal and withdrawal policy at the time the insurer contracts with the health  
26 care provider to participate in the provider network, and when changed  
27 thereafter;

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

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

9 (9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS  
 10 304.17A-700 to 304.17A-730; and

11 **(10) Notify the covered person that:**

12 **(a) Some health care providers may not be included in the health benefit plan's**  
 13 **provider network; and**

14 **(b) Nonparticipating providers may balance bill the covered person for**  
 15 **amounts not paid by the health benefit plan unless the health care services**  
 16 **are subject to the balance billing prohibition under Section 3 of this Act.**

17 ➔Section 8. KRS 304.17A-505 is amended to read as follows:

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

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

26 (a) Covered services and benefits to which the enrollee or other covered person is  
 27 entitled;

- 1 (b) Restrictions or limitations on covered services and benefits;
- 2 (c) Financial responsibility of the covered person, including copayments and  
3 deductibles;
- 4 (d) Prior authorization and any other review requirements with respect to  
5 accessing covered services;
- 6 (e) Where and in what manner covered services may be obtained;
- 7 (f) Changes in covered services or benefits, including any addition, reduction, or  
8 elimination of specific services or benefits;
- 9 (g) The covered person's right to the following:
- 10 1. A utilization review and the procedure for initiating a utilization review,  
11 if an insurer elects to provide utilization review;
- 12 2. An internal appeal of a utilization review made by or on behalf of the  
13 insurer with respect to the denial, reduction, or termination of a health  
14 care benefit or the denial of payment for a health care service, and the  
15 procedure to initiate an internal appeal; and
- 16 3. An external review and the procedure to initiate the external review  
17 process;
- 18 (h) Measures in place to ensure the confidentiality of the relationship between an  
19 enrollee and a health care provider;
- 20 (i) Other information as the commissioner shall require by administrative  
21 regulation;
- 22 (j) A summary of the drug formulary, including, but not limited to, a listing of the  
23 most commonly used drugs, drugs requiring prior authorization, any  
24 restrictions, limitations, and procedures for authorization to obtain drugs not  
25 on the formulary and, upon request of an insured or enrollee, a complete drug  
26 formulary; ~~and~~
- 27 (k) A statement informing the insured or enrollee that if the provider meets the

1 insurer's enrollment criteria and is willing to meet the terms and conditions for  
2 participation, the provider has the right to become a provider for the insurer;

3 and

4 (l) A statement informing the insured that:

5 1. Some health care providers may not be included in the health benefit  
6 plan's provider network; and

7 2. Nonparticipating providers may balance bill the covered person for  
8 amounts not paid by the health benefit plan unless the health care  
9 services are subject to the balance billing prohibition under Section 3  
10 of this Act.

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

13 ➔SECTION 9. A NEW SECTION OF KRS CHAPTER 365 IS CREATED TO  
14 READ AS FOLLOWS:

15 (1) If the Attorney General receives a referral from the commissioner of insurance  
16 indicating that any person has exhibited a pattern of intentionally violating  
17 Section 3 of this Act, the Attorney General may bring a civil action in the name of  
18 the Commonwealth to enjoin the person from the violation.

19 (2) If the Attorney General prevails in an action brought under this section, the  
20 Attorney General may recover attorney's fees, costs, and expenses, including  
21 court costs and witness fees, incurred in bringing the action.

22 (3) Nothing in this section shall be construed to prevent an insured from bringing an  
23 action to enforce the protections against balance billing set forth in Section 3 of  
24 this Act.

25 ➔Section 10. KRS 18A.225 is amended to read as follows:

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

27 1. Any person, including an elected public official, who is regularly

- 1 employed by any department, office, board, agency, or branch of state  
2 government; or by a public postsecondary educational institution; or by  
3 any city, urban-county, charter county, county, or consolidated local  
4 government, whose legislative body has opted to participate in the state-  
5 sponsored health insurance program pursuant to KRS 79.080; and who  
6 is either a contributing member to any one (1) of the retirement systems  
7 administered by the state, including but not limited to the Kentucky  
8 Retirement Systems, Kentucky Teachers' Retirement System, the  
9 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is  
10 receiving a contractual contribution from the state toward a retirement  
11 plan; or, in the case of a public postsecondary education institution, is an  
12 individual participating in an optional retirement plan authorized by  
13 KRS 161.567; or is eligible to participate in a retirement plan  
14 established by an employer who ceases participating in the Kentucky  
15 Employees Retirement System pursuant to KRS 61.522 whose  
16 employees participated in the health insurance plans administered by the  
17 Personnel Cabinet prior to the employer's effective cessation date in the  
18 Kentucky Employees Retirement System;
- 19 2. Any certified or classified employee of a local board of education;
- 20 3. Any elected member of a local board of education;
- 21 4. Any person who is a present or future recipient of a retirement  
22 allowance from the Kentucky Retirement Systems, Kentucky Teachers'  
23 Retirement System, the Legislators' Retirement Plan, the Judicial  
24 Retirement Plan, or the Kentucky Community and Technical College  
25 System's optional retirement plan authorized by KRS 161.567, except  
26 that a person who is receiving a retirement allowance and who is age  
27 sixty-five (65) or older shall not be included, with the exception of

- 1 persons covered under KRS 61.702(4)(c), unless he or she is actively  
2 employed pursuant to subparagraph 1. of this paragraph; and
- 3 5. Any eligible dependents and beneficiaries of participating employees  
4 and retirees who are entitled to participate in the state-sponsored health  
5 insurance program;
- 6 (b) The term "health benefit plan" for the purposes of this section means a health  
7 benefit plan as defined in KRS 304.17A-005;
- 8 (c) The term "insurer" for the purposes of this section means an insurer as defined  
9 in KRS 304.17A-005; and
- 10 (d) The term "managed care plan" for the purposes of this section means a  
11 managed care plan as defined in KRS 304.17A-500.
- 12 (2) (a) The secretary of the Finance and Administration Cabinet, upon the  
13 recommendation of the secretary of the Personnel Cabinet, shall procure, in  
14 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,  
15 from one (1) or more insurers authorized to do business in this state, a group  
16 health benefit plan that may include but not be limited to health maintenance  
17 organization (HMO), preferred provider organization (PPO), point of service  
18 (POS), and exclusive provider organization (EPO) benefit plans encompassing  
19 all or any class or classes of employees. With the exception of employers  
20 governed by the provisions of KRS Chapters 16, 18A, and 151B, all  
21 employers of any class of employees or former employees shall enter into a  
22 contract with the Personnel Cabinet prior to including that group in the state  
23 health insurance group. The contracts shall include but not be limited to  
24 designating the entity responsible for filing any federal forms, adoption of  
25 policies required for proper plan administration, acceptance of the contractual  
26 provisions with health insurance carriers or third-party administrators, and  
27 adoption of the payment and reimbursement methods necessary for efficient

1 administration of the health insurance program. Health insurance coverage  
2 provided to state employees under this section shall, at a minimum, contain  
3 the same benefits as provided under Kentucky Kare Standard as of January 1,  
4 1994, and shall include a mail-order drug option as provided in subsection  
5 (13) of this section. All employees and other persons for whom the health care  
6 coverage is provided or made available shall annually be given an option to  
7 elect health care coverage through a self-funded plan offered by the  
8 Commonwealth or, if a self-funded plan is not available, from a list of  
9 coverage options determined by the competitive bid process under the  
10 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available  
11 during annual open enrollment.

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

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

23 (d) Any carrier bidding to offer health care coverage to employees shall agree to  
24 provide enrollment, claims, and utilization data to the Commonwealth in a  
25 format specified by the Personnel Cabinet with the understanding that the data  
26 shall be owned by the Commonwealth; to provide data in an electronic form  
27 and within a time frame specified by the Personnel Cabinet; and to be subject



1 to penalties for noncompliance with data reporting requirements as specified  
2 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions  
3 to protect the confidentiality of each individual employee; however,  
4 confidentiality assertions shall not relieve a carrier from the requirement of  
5 providing stipulated data to the Commonwealth.

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

21 (f) If any agency participating in the state-sponsored employee health insurance  
22 program for its active employees terminates participation and there is a state  
23 appropriation for the employer's contribution for active employees' health  
24 insurance coverage, then neither the agency nor the employees shall receive  
25 the state-funded contribution after termination from the state-sponsored  
26 employee health insurance program.

27 (g) Any funds in flexible spending accounts that remain after all reimbursements

1           have been processed shall be transferred to the credit of the state-sponsored  
2           health insurance plan's appropriation account.

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

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

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

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

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

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

25           (5) No payment of premium by any department, board, agency, public postsecondary  
26           educational institution, or branch of state, city, urban-county, charter county,  
27           county, or consolidated local government shall constitute compensation to an

1 insured employee for the purposes of any statute fixing or limiting the  
2 compensation of such an employee. Any premium or other expense incurred by any  
3 department, board, agency, public postsecondary educational institution, or branch  
4 of state, city, urban-county, charter county, county, or consolidated local  
5 government shall be considered a proper cost of administration.

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

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

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

16 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of  
17 State Health Insurance Subscribers to advise the secretary or his designee regarding  
18 the state-sponsored health insurance program for employees. The secretary shall  
19 appoint, from a list of names submitted by appointing authorities, members  
20 representing school districts from each of the seven (7) Supreme Court districts,  
21 members representing state government from each of the seven (7) Supreme Court  
22 districts, two (2) members representing retirees under age sixty-five (65), one (1)  
23 member representing local health departments, two (2) members representing the  
24 Kentucky Teachers' Retirement System, and three (3) members at large. The  
25 secretary shall also appoint two (2) members from a list of five (5) names submitted  
26 by the Kentucky Education Association, two (2) members from a list of five (5)  
27 names submitted by the largest state employee organization of nonschool state

1 employees, two (2) members from a list of five (5) names submitted by the  
2 Kentucky Association of Counties, two (2) members from a list of five (5) names  
3 submitted by the Kentucky League of Cities, and two (2) members from a list of  
4 names consisting of five (5) names submitted by each state employee organization  
5 that has two thousand (2,000) or more members on state payroll deduction. The  
6 advisory committee shall be appointed in January of each year and shall meet  
7 quarterly.

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

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

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

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

1           accordance with Kentucky law.

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

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

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

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

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

20           (17) If a state employee's residence and place of employment are in the same county, and  
21           if the hospital located within that county does not offer surgical services, intensive  
22           care services, obstetrical services, level II neonatal services, diagnostic cardiac  
23           catheterization services, and magnetic resonance imaging services, the employee  
24           may select a plan available in a contiguous county that does provide those services,  
25           and the state contribution for the plan shall be the amount available in the county  
26           where the plan selected is located.

27           (18) If a state employee's residence and place of employment are each located in counties

1 in which the hospitals do not offer surgical services, intensive care services,  
2 obstetrical services, level II neonatal services, diagnostic cardiac catheterization  
3 services, and magnetic resonance imaging services, the employee may select a plan  
4 available in a county contiguous to the county of residence that does provide those  
5 services, and the state contribution for the plan shall be the amount available in the  
6 county where the plan selected is located.

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

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

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

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

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

25 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the  
26 carrier all of the counties included in its bid within the region. If the Personnel  
27 Cabinet deems the bids submitted in accordance with this subsection to be in

1 the best interests of state employees in a region, the cabinet may award the  
 2 contract for that region to no more than two (2) carriers; and

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

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

12 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or  
 13 after the effective date of this Act~~[July 12, 2006]~~, to public employees pursuant to  
 14 this section shall comply with:

15 (a) Sections 3 and 4 of this Act;

16 (b) KRS 304.17A-270 and 304.17A-525;

17 (c) KRS 304.17A-600 to 304.17A-633;

18 (d) KRS 205.593;

19 (e) KRS 304.17A-700 to 304.17A-730;

20 (f) KRS 304.14-135;

21 (g) KRS 304.17A-580 and 304.17A-641;

22 (h) KRS 304.99-123;

23 (i) KRS 304.17A-138; and

24 (j) Administrative regulations promulgated pursuant to statutes listed in this  
 25 subsection.~~[the provisions of KRS 304.17A-270 and 304.17A-525.~~

26 ~~(23) Any fully insured health benefit plan or self-insured plan issued or renewed on or~~  
 27 ~~after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to~~

1       ~~304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to~~  
 2       ~~304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to~~  
 3       ~~uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641~~  
 4       ~~pertaining to emergency medical care, KRS 304.99-123, and any administrative~~  
 5       ~~regulations promulgated thereunder.~~

6       ~~(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or~~  
 7       ~~after July 1, 2019, to public employees pursuant to this section shall comply with~~  
 8       ~~KRS 304.17A-138.]~~

9       ➔Section 11. KRS 304.17A-0954 is amended to read as follows:

10      (1) Notwithstanding any other provision of this chapter, the amount or rate of  
 11      premiums for an employer-organized association health plan may be determined,  
 12      subject to the restrictions of subsection (2) of this section, based upon the  
 13      experience or projected experience of the employer-organized associations whose  
 14      employers obtain group coverage under the plan.

15      (2) The following restrictions shall be applied in calculating the permissible amount or  
 16      rate of premiums for an employer-organized association health insurance plan  
 17      issued to an employer-organized association as defined in KRS 304.17A-  
 18      005~~(14)~~~~(12)~~(a) to (c):

19      (a) The premium rates charged during a rating period to members of the  
 20      employer-organized association with similar characteristics for the same or  
 21      similar coverage, or the premium rates that could be charged to a member of  
 22      the employer-organized association under the rating system for that class of  
 23      business, shall not vary from its own index rate by more than fifty percent  
 24      (50%) of its own index rate;

25      (b) The percentage increase in the premium rate charged to an employer member  
 26      of an employer-organized association for a new rating period shall not exceed  
 27      the sum of the following:



- 1           1. The percentage change in the new business premium rate for the  
2           employer-organized association measured from the first day of the prior  
3           rating period to the first day of the new rating period;
- 4           2. Any adjustment, not to exceed twenty percent (20%) annually and  
5           adjusted pro rata for rating period of less than one (1) year, due to the  
6           claims experience, mental and physical condition, including medical  
7           condition, medical history, and health service utilization, or duration of  
8           coverage of the member as determined from the insurer's rate manual;  
9           and
- 10          3. Any adjustment due to change in coverage or change in the case  
11          characteristics of the member as determined by the insurer's rate manual;
- 12          (c) In utilizing case characteristics, the ratio of the highest rate factor to the  
13          lowest rate factor within a class of business shall not exceed five to one (5:1).  
14          For purpose of this limitation, case characteristics include age, gender,  
15          occupation or industry, and geographic area; and
- 16          (d) Unless the written consent of the employer-organized association is filed with  
17          the department, the index rate for the employer-organized association shall be  
18          calculated solely with respect to that employer-organized association and shall  
19          not be tied to, linked to, or otherwise adversely affected by any other index  
20          rate used by the issuing insurer.
- 21          (3) For the purpose of this section, a health insurance contract that utilizes a restricted  
22          provider network shall not be considered similar coverage to a health insurance  
23          contract that does not utilize a restricted provider network if utilization of the  
24          restricted provider network results in measurable differences in claims costs.
- 25          ➔Section 12. KRS 304.17A-096 is amended to read as follows:
- 26          (1) An insurer authorized to engage in the business of insurance in the Commonwealth  
27          of Kentucky may offer one (1) or more basic health benefit plans in the individual,

1 small group, and employer-organized association markets. A basic health benefit  
 2 plan shall cover physician, pharmacy, home health, preventive, emergency, and  
 3 inpatient and outpatient hospital services in accordance with the requirements of  
 4 this subtitle. If vision or eye services are offered, these services may be provided by  
 5 an ophthalmologist or optometrist.

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

8 (3) An insurer in the individual, small group, or employer-organized association  
 9 markets that offers a basic health benefit plan may offer a basic health benefit plan  
 10 that excludes from coverage any state-mandated health insurance benefit, except  
 11 that the basic health benefit plan shall include coverage for diabetes as provided in  
 12 KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic  
 13 benefits as provided in KRS 304.17A-171, mammograms as provided in KRS  
 14 304.17A-133, and those mandated benefits specified under federal law.

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

18 ➔Section 13. KRS 304.17A-500 is amended to read as follows:

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

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

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

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

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

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

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

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

6 2.—Serious impairment to bodily functions; or

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

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

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

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

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

15 (5)[(6)] "Grievance" means a written complaint submitted by or on behalf of an  
 16 enrollee;

17 (6)[(7)] "Health insurance policy" means "health benefit plan" as defined in KRS  
 18 304.17A-005;

19 [(8)—"Insurer" has the meaning provided in KRS 304.17A-005;]

20 (7)[(9)] "Managed care plan" means a health insurance policy that integrates the  
 21 financing and delivery of appropriate health care services to enrollees by  
 22 arrangements with participating providers who are selected to participate on the  
 23 basis of explicit standards to furnish a comprehensive set of health care services and  
 24 financial incentives for enrollees to use the participating providers and procedures  
 25 provided for in the plan;

26 (8)[(10)]—"Participating health care provider" means a health care provider that has  
 27 entered into an agreement with an insurer to provide health care services;

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

3 (9)~~(12)~~ "Record" means any written, printed, or electronically recorded material  
4 maintained by a provider in the course of providing health services to a patient  
5 concerning the patient and the services provided. "Record" also includes the  
6 substance of any communication made by a patient to a provider in confidence  
7 during or in connection with the provision of health services to a patient or  
8 information otherwise acquired by the provider about a patient in confidence and in  
9 connection with the provision of health services to a patient;

10 (10)~~(13)~~ "Risk sharing arrangement" means any agreement that allows an insurer to  
11 share the financial risk of providing health care services to enrollees or insureds  
12 with another entity or provider where there is a chance of financial loss to the entity  
13 or provider as a result of the delivery of a service. A risk sharing arrangement shall  
14 not include a reinsurance contract with an accredited or admitted reinsurer;

15 (11)~~(14)~~ "Urban area" means a classification code whereby the zip code population  
16 density is greater than three thousand (3,000) persons per square mile; and

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

25 ➔Section 14. KRS 304.17A-580 is amended to read as follows:

26 (1) An insurer offering health benefit plans shall educate its insureds about the  
27 availability, location, and appropriate use of emergency and other medical services,

1 cost-sharing provisions for emergency services, and the availability of care outside  
2 an emergency department.

3 (2) An insurer offering health benefit plans shall cover emergency medical conditions  
4 and shall pay for emergency department screening and stabilization services both in-  
5 network and out-of-network without prior authorization for conditions that  
6 reasonably appear to a prudent layperson to constitute an emergency medical  
7 condition based on the patient's presenting symptoms and condition. An insurer  
8 shall be prohibited from denying the emergency department services and altering  
9 the level of coverage or cost-sharing requirements for any condition or conditions  
10 that constitute an emergency medical condition as defined in Section 1 of this  
11 Act ~~[KRS 304.17A-500]~~.

12 (3) Emergency department personnel shall contact a patient's primary care provider or  
13 insurer, as appropriate, to discuss follow-up and poststabilization care and promote  
14 continuity of care.

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

18 ➔Section 15. KRS 304.17A-649 is amended to read as follows:

19 The commissioner shall promulgate administrative regulations necessary to implement  
20 the provisions of KRS ~~{304.17A-640, }304.17A-641, 304.17A-643, 304.17A-645, and~~  
21 304.17A-647.

22 ➔Section 16. KRS 304.17B-001 is amended to read as follows:

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

- 24 (1) "Administrator" is defined in KRS 304.9-051(1);  
25 (2) "Agent" is defined in KRS 304.9-020;  
26 (3) "Assessment process" means the process of assessing and allocating guaranteed  
27 acceptance program losses or Kentucky Access funding as provided for in KRS

1 304.17B-021;

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

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

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

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

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

11 ~~(7)~~~~(9)~~ "Enrollee" means a person who is enrolled in a health benefit plan offered  
12 under Kentucky Access;

13 ~~(8)~~~~(10)~~ "Eligible individual" is defined in KRS 304.17A-005~~((11))~~;

14 ~~(9)~~~~(11)~~ "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed  
15 Acceptance Program established and operated under KRS 304.17A-400 to  
16 304.17A-480;

17 ~~(10)~~~~(12)~~ "Guaranteed acceptance program participating insurer" means an insurer that  
18 offered health benefit plans through December 31, 2000, in the individual market to  
19 guaranteed acceptance program qualified individuals;

20 ~~(11)~~~~(13)~~ "Health benefit plan" is defined in KRS 304.17A-005~~((22))~~;

21 ~~(12)~~~~(14)~~ "High-cost condition" means acquired immune deficiency syndrome (AIDS),  
22 angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary  
23 insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia,  
24 Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic  
25 cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy,  
26 myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic  
27 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease,

1 chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the  
2 bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short  
3 gestation period for a newborn child, and low birth weight of a newborn child;

4 ~~(13)~~~~(15)~~ "Incurred losses" means for Kentucky Access the excess of claims paid over  
5 premiums received;

6 ~~(14)~~~~(16)~~ "Insurer" is defined in KRS 304.17A-005~~(29)~~;

7 ~~(15)~~~~(17)~~ "Kentucky Access" means the program established in accordance with KRS  
8 304.17B-001 to 304.17B-031;

9 ~~(16)~~~~(18)~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

10 ~~(17)~~~~(19)~~ "Kentucky Health Care Improvement Authority" means the board established  
11 to administer the program initiatives listed in KRS 304.17B-003~~(5)~~;

12 ~~(18)~~~~(20)~~ "Kentucky Health Care Improvement Fund" means the fund established for  
13 receipt of the Kentucky tobacco master settlement moneys for program initiatives  
14 listed in KRS 304.17B-003~~(5)~~;

15 ~~(19)~~~~(21)~~ "MARS" means the Management Administrative Reporting System  
16 administered by the Commonwealth;

17 ~~(20)~~~~(22)~~ "Medicaid" means coverage in accordance with Title XIX of the Social  
18 Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

19 ~~(21)~~~~(23)~~ "Medicare" means coverage under both Parts A and B of Title XVIII of the  
20 Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

21 ~~(22)~~~~(24)~~ "Office" means the Office of Health Data and Analytics in the Cabinet for  
22 Health and Family Services;

23 ~~(23)~~~~(25)~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~(6)~~;

24 ~~(24)~~~~(26)~~ "Standard health benefit plan" means a health benefit plan that meets the  
25 requirements of KRS 304.17A-250;

26 ~~(25)~~~~(27)~~ "Stop-loss carrier" means any person providing stop-loss health insurance  
27 coverage;

1 ~~(26)~~~~(28)~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured  
2 employer-controlled or bona fide associations; and

3 ~~(27)~~~~(29)~~ "Utilization management" is defined in KRS 304.17A-500~~(12)~~.

4 ➔Section 17. KRS 304.17B-015 is amended to read as follows:

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

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

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

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

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

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

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

24 (a) 1. The individual has, or is eligible for, on the effective date of coverage  
25 under Kentucky Access, substantially similar coverage under another  
26 contract or policy, unless the individual was issued coverage from a  
27 GAP participating insurer as a GAP qualified individual prior to January



1                   1, 2001. A GAP qualified individual shall be automatically eligible for  
2                   coverage under Kentucky Access without regard to the requirements of  
3                   subsection (2) of this section; or

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

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

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

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

18               (d) Except for covered benefits paid under the standard health benefit plan as  
19               specified in KRS 304.17B-019, Kentucky Access has paid two million dollars  
20               (\$2,000,000) in covered benefits per individual. The maximum limit under  
21               this paragraph may be increased by the office;

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

25               (f) The individual's premium, deductible, coinsurance, or copayment is partially  
26               or entirely paid or reimbursed by an individual or entity other than the  
27               individual or the individual's parent, grandparent, spouse, child, stepchild,

1 father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-  
2 law, sister-in-law, grandchild, guardian, or court-appointed payor.

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

6 ➔Section 18. KRS 304.17B-033 is amended to read as follows:

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

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

17 ➔Section 19. KRS 304.17C-010 is amended to read as follows:

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

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

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

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

24 (4) "Insurer" means any insurance company, health maintenance organization, self-  
25 insurer or multiple employer welfare arrangement not exempt from state regulation  
26 by ERISA, provider-sponsored integrated health delivery network, self-insured  
27 employer-organized association, nonprofit hospital, medical-surgical, dental, health

1 service corporation, or limited health service organization authorized to transact  
2 health insurance business in Kentucky who offers a limited health service benefit  
3 plan; and

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

10 ➔Section 20. KRS 304.18-114 is amended to read as follows:

11 (1) As used in this section:

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

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

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

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

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

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

27 (c) The former group member must pay the monthly, quarterly, semiannual, or

1           annual premium, at the option of the applicant, to the insurer not later than  
2           thirty-one (31) days after notice pursuant to subsection (5) of this section.

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

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

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

9           1. The effective date of the conversion policy; or

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

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

16       (d) The effective date of the conversion health insurance policy shall be the date  
17           of termination of coverage under the group policy; and

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

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

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

26       (b) On the effective date of coverage, the applicant is or could be covered by  
27           another group coverage (insured or uninsured) or, the applicant is covered by

1 substantially similar benefits by another individual hospital, surgical, or  
2 medical expenses insurance policy; or

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

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

10 (a) For group policies delivered, issued for delivery, or renewed after July 15,  
11 2002, the insurer shall give written notice of the right to conversion health  
12 insurance coverage to any former group member entitled to conversion  
13 coverage under this section upon notice from the group policyholder that the  
14 group member has terminated membership in the group, upon termination of  
15 the former group member's continued group health insurance coverage  
16 pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-  
17 005~~{(7)}~~, or upon termination of the group policy for any reason. The written  
18 notice shall clearly explain the former group member's right to a conversion  
19 policy.

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

23 (c) If a former group member becomes entitled to obtain conversion health  
24 insurance coverage, pursuant to this section, and the insurer fails to give the  
25 former group member written notice of the right, pursuant to this subsection,  
26 the insurer shall give written notice to the former group member as soon as  
27 practicable after being notified of the insurer's failure to give written notice of

1 conversion rights to the former group member and such former group member  
2 shall have an additional period within which to exercise his conversion rights.  
3 The additional period shall expire sixty (60) days after written notice is  
4 received from the insurer. Written notice delivered or mailed to the last known  
5 address of the former group member shall constitute the giving of notice for  
6 the purpose of this paragraph. If a former group member makes application  
7 and pays the premium, for conversion health insurance coverage within the  
8 additional period allowed by this paragraph, the effective date of conversion  
9 health insurance coverage shall be the date of termination of group health  
10 insurance coverage. However, nothing in this subsection shall require an  
11 insurer to give notice or provide conversion coverage to a former group  
12 member ninety (90) days after termination of the former group member's  
13 group coverage.

14 ➔Section 21. KRS 304.38A-010 is amended to read as follows:

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

- 16 (1) "Enrollee" means an individual who is enrolled in a limited health services benefit  
17 plan;
- 18 (2) "Evidence of coverage" means any certificate, agreement, contract, or other  
19 document issued to an enrollee stating the limited health services to which the  
20 enrollee is entitled. All coverages described in an evidence of coverage issued by a  
21 limited health service organization are deemed to be "limited health services benefit  
22 plans" to the extent defined in KRS 304.17C-010 unless exempted by the  
23 commissioner;
- 24 (3) "Limited health service" means dental care services, vision care services, mental  
25 health services, substance abuse services, chiropractic services, pharmaceutical  
26 services, podiatric care services, and such other services as may be determined by  
27 the commissioner to be limited health services. Limited health service shall not

1 include hospital, medical, surgical, or emergency services except as these services  
2 are provided incidental to the limited health services set forth in this subsection;

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

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

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

12 ➔Section 22. KRS 304.39-241 is amended to read as follows:

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

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

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

20 (3) Medicaid;

21 (4) Medicare; or

22 (5) A Medicare supplement provider.

23 ➔Section 23. The following KRS section is repealed:

24 304.17A-640 Definitions for KRS 304.17A-640 et seq.

25 ➔Section 24. This Act shall take effect January 1, 2021.