AN ACT relating to surprise billing.

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

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

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

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

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

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

(4) "Emergency medical condition" means:

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

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

2. Serious impairment to bodily functions; or

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

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

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

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

(5) "Enrollee" means a person who is enrolled in a plan offered by a health maintenance

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

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

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

(8) "Cost-sharing" means coinsurance, deductibles, copayments, and any other out-of-pocket expenses;

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

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

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

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

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

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

(15) ~~[(12)]~~ "Record" means any written, printed, or electronically recorded material maintained by a provider in the course of providing health ***care*** services to a patient concerning the patient and the services provided. "Record" also includes the substance of any communication made by a patient to a provider in confidence

during or in connection with the provision of health ***care*** services to a patient or information otherwise acquired by the provider about a patient in confidence and in connection with the provision of health ***care*** services to a patient;

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

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

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

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

(1) As used in this section, "covered health care services":

(a) Means:

1. Health care services that are covered under the covered person's health benefit plan; or

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

(b) Does not include emergency medical conditions or emergency department screening and stabilization services covered under Section 3 of this Act.

(2) All health benefit plans issued or renewed on or after the effective date of this Act shall provide coverage for covered health care services that are provided by a nonparticipating health care provider to a covered person at an in-network facility.

(3) For health care services covered pursuant to this section, an insurer shall:

(a) Reimburse the nonparticipating health care provider at the greater of the following, less any cost-sharing owed by the insured:

1. a. Except as provided under subdivisions b. and c. of this subparagraph, the amount negotiated with participating health care providers for the health care services;

b. If there is more than one (1) amount negotiated with participating health care providers for the health care services, the median of those amounts. In determining the median amount, the amount negotiated with each participating health care provider shall be treated as a separate payment amount, regardless of whether the same amount is paid to more than one (1) provider; or

c. If there is no per-service amount negotiated with participating heath care providers, such as under a capitation or other similar arrangement, this subparagraph shall be disregarded when determining the reimbursement under this paragraph;

2. The amount for the health care services calculated using the same method the health benefit plan generally uses to determine payments for out-of-network health care services; or

3. The amount that would be paid under parts A or B of the Medicare

program, Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395c to 1395w-6, as amended, for the health care services;

(b) Send the reimbursement, if any, directly to the nonparticipating health care provider; and

(c) Along with any reimbursement required under this subsection, notify the nonparticipating health care provider of any cost-sharing that is owed by the covered person for the covered health care services under the covered person's health benefit plan. The cost-sharing owed shall not exceed the cost-sharing that would be owed by a covered person if the services were provided by a participating health care provider; and

(4) A nonparticipating health care provider shall not collect, or attempt to collect, any payment amount from a covered person for health care services covered under this section other than for the cost-sharing owed under the covered person's health benefit plan.

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

➔Section 3. KRS 304.17A-580 is amended to read as follows:

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

(2) An insurer offering health benefit plans shall cover emergency medical conditions and shall pay for emergency department screening and stabilization services both in-network and out-of-network without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based on the patient's presenting symptoms and condition. An insurer

shall be prohibited from denying the emergency department services and altering the level of coverage or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition as defined in KRS 304.17A-500.

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

(4) (a) For emergency medical conditions and emergency department screening and stabilization services covered pursuant to this section, if the emergency medical condition was treated or the screening and stabilization services were provided by a nonparticipating health care provider at an in-network facility, a covered person's insurer shall:

1. Reimburse a nonparticipating health care provider at the greater of the following, less any cost-sharing owed by the insured:

a. i. Except as provided under subparts ii. and iii. of this subdivision, the amount negotiated with participating health care providers for the health care services;

ii. If there is more than one (1) amount negotiated with participating health care providers for the health care services, the median of those amounts. In determining the median amount, the amount negotiated with each participating health care provider shall be treated as a separate payment amount, regardless of whether the same amount is paid to more than one (1) provider; or

iii. If there is no per-service amount negotiated with participating health care providers, such as under a capitation or other similar arrangement, this subdivision shall be disregarded when determining the reimbursement

amount under this paragraph;

b. The amount for the health care services calculated using the same method the health benefit plan generally uses to determine payments for out-of-network health care services; or

c. The amount that would be paid under parts A or B of the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395c to 1395w-6, as amended, for the health care services;

2. Send the reimbursement, if any, directly to the nonparticipating health care provider; and

3. Along with any reimbursement required under this subsection, notify the nonparticipating health care provider of any cost-sharing that is owed by the covered person for the covered health care services under the covered person's health benefit plan. The cost-sharing owed shall not exceed the cost-sharing that would be owed by the covered person if the services were provided by a participating health care provider.

(b) A nonparticipating health care provider shall not collect, or attempt to collect, any payment amount from a covered person for health care services covered under this subsection other than for the cost-sharing owed under the covered person's health benefit plan.

(c) Except as provided in paragraph (a) of this subsection relating to reimbursement rates, all claims and reimbursements covered by this subsection shall be subject to KRS 304.14-135, 304.17A-700 to 304.17A-730, and 304.99-123.

(5) (a) If a covered person with an emergency medical condition has been stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 42 U.S.C. sec. 1395dd, in the emergency department

of a hospital that is a nonparticipating health care provider, and an insurer under its health benefit plan requires prior authorization for poststabilization treatment, approval or denial under the preauthorization requirement shall be provided in a timely manner appropriate to conditions of the patient and delivery of the services, but in no case to exceed two (2) hours from the time the request is made and all relevant information is provided. The insurer's failure to make a determination within the two (2) hour time frame shall constitute an authorization for the hospital to provide the medical service for which prior authorization was sought.

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

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

➔Section 4. KRS 304.17A-254 is amended to read as follows:

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

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

(a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider,

professional office address, telephone number, and specialty designations of the network provider, if any; and

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

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

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

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

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

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

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

(b) Disclose to the covered person or to another person on behalf of a covered

person other information determined by the health care provider to be in the best interests of the covered person;

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

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

(b) For providers that are a health facility, a clause requiring that if the health facility enters into any subcontract agreement with another provider for the provision of health care services to a covered person, the subcontract agreement shall:

1. Require a subcontracted provider that is a nonparticipating provider, for any health care services furnished by the subcontracted provider at the health facility, to comply with Section 2 of this Act and subsection (4) of Section 3 of this Act; and

2. Include notice to a subcontracted provider of the reimbursement limitations of subparagraph 1. of this paragraph.

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

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health

care provider to participate in the provider network, and when changed thereafter;

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

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

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

➔Section 5. KRS 304.17A-527 is amended to read as follows:

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

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

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

2. Insolvency of the managed care plan, or

3. Breach of the agreement,

bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the~~[subscriber, dependent of subscriber,]~~ enrollee~~[,]~~ or any persons acting on ***the enrollee's***~~[their]~~ behalf, for services provided in accordance with the provider agreement. This

provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services;

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

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

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

(e) ***1.*** A clause requiring that if a provider enters into any subcontract agreement with another provider to provide their ~~[licensed]~~health care services to the ~~[subscriber, dependent of the subscriber, or]~~ enrollee of a

managed care plan where the subcontracted provider will bill the managed care plan or~~[subscriber or]~~ enrollee directly for the subcontracted services, the subcontract agreement ***shall:***

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

b. Be filed with the commissioner in accordance with this subsection.

2. For providers that are a health facility, a clause requiring that if the health facility enters into any subcontract agreement with another provider for the provision of health care services to an enrollee, the subcontract agreement shall:

a. Require a subcontracted provider that is a nonparticipating provider, for any health care services furnished by the subcontracted provider at the health facility, to comply with Section 2 of this Act and subsection (4) of Section 3 of this Act; and

b. Include notice to a subcontracted provider of the reimbursement limitations of subdivision a. of this subparagraph.

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

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

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

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

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

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

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

➔Section 6. KRS 304.17A-565 is amended to read as follows:

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

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

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

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

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

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who

is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

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

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

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

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

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

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

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

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more insurers authorized to do business in this state, a group health benefit plan that may include but not be limited to health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of employees. With the exception of employers governed by the provisions of KRS Chapters 16, 18A, and 151B, all employers of any class of employees or former employees shall enter into a contract with the Personnel Cabinet prior to including that group in the state health insurance group. The contracts shall include but not be limited to designating the entity responsible for filing any federal forms, adoption of policies required for proper plan administration, acceptance of the contractual provisions with health insurance carriers or third-party administrators, and adoption of the payment and reimbursement methods necessary for efficient administration of the health insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care

coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

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

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

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

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

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

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

(h) Each entity participating in the state-sponsored health insurance program shall provide an amount at least equal to the state contribution rate for the employer portion of the health insurance premium. For any participating entity that used

the state payroll system, the employer contribution amount shall be equal to but not greater than the state contribution rate.

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

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

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

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

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

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

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

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

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

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or his designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The

advisory committee shall be appointed in January of each year and shall meet quarterly.

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

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

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

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

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

retail pharmacy shall not be required to dispense by mail.

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

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

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

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

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

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

county where the plan selected is located.

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

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

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

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

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

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

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

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

after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

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

(a) Sections 2 and 3 of this Act;

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

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

(d) KRS 205.593;

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

(f) KRS 304.14-135;

(g) KRS 304.99-123; and

(h) KRS 304.17A-138; and

(i) Administrative regulations promulgated pursuant to statutes listed in this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(21) "MARS" means the Management Administrative Reporting System administered by the Commonwealth;

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

(23) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social

Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

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

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

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

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

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

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

➔Section 9. KRS 304.17A-649 is amended to read as follows:

The commissioner shall promulgate administrative regulations necessary to implement the provisions of KRS ~~[304.17A-640, 304.17A-641,]~~304.17A-643, 304.17A-645, and 304.17A-647.

➔Section 10. The following KRS sections are repealed:

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

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

➔Section 11. This Act takes effect on January 1, 2021.