AN ACT relating to payments from insureds.

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

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

An insurer shall not prohibit a health care provider or any other health professional from accepting or negotiating payments, or otherwise limit or penalize the acceptance or negotiation of payments by providers or professionals, from an insured for:

(1) Noncovered benefits or services; or

(2) Covered benefits or services if the insured voluntarily chooses to:

(a) Not make, abandon, or withdraw a claim for the benefits or services; or

(b) Pay in excess of any cost sharing or other amounts owed for the benefits or services under the insured's health plan or the insurer's contract with the provider or professional.

➔Section 2. 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 KRS 304.17A-500*** but provides financial incentives for a covered person to access a network of providers shall:

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

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

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

format;

(2) Assure that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be balanced billed by the in-network provider**,** except for**:**

(a) Deductibles, co-pays, coinsurance amounts, and noncovered benefits; ***or***

(b) Amounts billed in accordance with Section 1 of this Act;

(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 clause stating that the insurer 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;

(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 3. 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 their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection ***or negotiation*** of deductible amounts, copayment amounts, coinsurance amounts, ~~[and]~~ amounts for noncovered services***, or payments in accordance with Section 1 of this Act***;

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

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

provider and the managed care plan;

(d) A clause stating that the insurer issuing a managed care plan ***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) 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*** ~~[must]~~ meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

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

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

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

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

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with KRS 304.17A-500 to 304.17A-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 4. KRS 304.17C-060 is amended to read as follows:

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

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

1. Nonpayment of moneys due to providers by the insurer;

2. Insolvency of the insurer; or

3. Breach of the agreement,

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

coinsurance amounts,~~[and]~~ amounts for noncovered services***, or payments in accordance with Section 5 of this Act***;

(b) 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 insurer; and

(c) A clause requiring that if a provider enters into any subcontract agreement with another provider to provide health care services to the subscriber, dependent of the subscriber, or enrollee of a limited health service benefit plan, the subcontract agreement must meet all requirements of this subtitle and that all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

(2) Each insurer shall establish procedures for changing an existing agreement with a participating provider, as defined in KRS 304.17A-235, which comply with KRS 304.17A-235.

(3) An insurer 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 the requirements of this subtitle in exercising any delegated administrative functions; and

(e) The insurer's oversight and compliance plan regarding the standards and

method of review.

(4) 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 5. KRS 304.17C-085 IS REPEALED AND REENACTED TO READ AS FOLLOWS:

An insurer shall not prohibit a health care provider or any other health professional from accepting or negotiating payments, or otherwise limit or penalize the acceptance or negotiation of payments by providers or professionals, from an insured for:

(1) Noncovered benefits or services; or

(2) Covered benefits or services if the insured voluntarily chooses to:

(a) Not make, abandon, or withdraw a claim for the benefits or services; or

(b) Pay in excess of any cost sharing or other amounts owed for the benefits or services under the insured's limited health service benefit plan or the insurer's contract with the provider or professional.