

1 AN ACT relating to health care.

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) "Creditable coverage":
- 9 (a) Means, with respect to an individual, coverage of the individual under any of
- 10 the following:
- 11 1. A group health plan;
- 12 2. Health insurance coverage;
- 13 3. Part A or Part B of Title XVIII of the Social Security Act;
- 14 4. Title XIX of the Social Security Act, other than coverage consisting
- 15 solely of benefits under section 1928;
- 16 5. Chapter 55 of Title 10, United States Code, including medical and dental
- 17 care for members and certain former members of the uniformed services,
- 18 and for their dependents; for purposes of Chapter 55 of Title 10, United
- 19 States Code, "uniformed services" means the Armed Forces and the
- 20 Commissioned Corps of the National Oceanic and Atmospheric
- 21 Administration and of the Public Health Service;
- 22 6. A medical care program of the Indian Health Service or of a tribal
- 23 organization;
- 24 7. A state health benefits risk pool;
- 25 8. A health plan offered under Chapter 89 of Title 5, United States Code,
- 26 such as the Federal Employees Health Benefit Program;
- 27 9. A public health plan as established or maintained by a state, the United

- 1 States government, a foreign country, or any political subdivision of a
2 state, the United States government, or a foreign country that provides
3 health coverage to individuals who are enrolled in the plan;
- 4 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
5 U.S.C. sec. 2504(e)); or
- 6 11. Title XXI of the Social Security Act, such as the State Children's Health
7 Insurance Program; and
- 8 (b) Does not include coverage consisting solely of coverage of excepted benefits
9 as defined in this section;
- 10 (9) "Dependent" means any individual who is or may become eligible for coverage
11 under the terms of an individual or group health benefit plan because of a
12 relationship to a participant;
- 13 (10) **"Emergency medical condition" means:**
- 14 **(a) A medical condition manifesting itself by acute symptoms of sufficient**
15 **severity, including severe pain, that a prudent layperson would reasonably**
16 **have cause to believe constitutes a condition in which the absence of**
17 **immediate medical attention could reasonably be expected to result in:**
- 18 **1. Placing the health of the individual or, with respect to a pregnant**
19 **woman, the health of the woman or her unborn child, in serious**
20 **jeopardy;**
- 21 **2. Serious impairment to bodily functions; or**
- 22 **3. Serious dysfunction of any organ or part; or**
- 23 **(b) With respect to a pregnant woman who is having contractions:**
- 24 **1. A situation in which there is inadequate time to effect a safe transfer**
25 **to another hospital before delivery; or**
- 26 **2. A situation in which transfer may pose a threat to the health or safety**
27 **of the woman or the unborn child;**

1 (11) "Employee benefit plan" means an employee welfare benefit plan or an employee
2 pension benefit plan or a plan which is both an employee welfare benefit plan and
3 an employee pension benefit plan as defined by ERISA;

4 (12)~~(11)~~ "Eligible individual" means an individual:

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

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

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

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

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

25 (13)~~(12)~~ "Employer-organized association" means any of the following:

26 (a) Any entity that was qualified by the commissioner as an eligible association
27 prior to April 10, 1998, and that has actively marketed a health insurance

1 program to its members since September 8, 1996, and which is not insurer-
2 controlled;

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

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

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

20 Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and
21 except as otherwise provided by the definition of "large group" contained in this
22 section, an employer-organized association shall not be treated as an association,
23 small group, or large group under this subtitle, except that an employer-organized
24 association as defined under paragraph (c) or (d) of this subsection shall be treated
25 as a large group under this subtitle;

26 ~~(14)~~⁽¹³⁾ "Employer-organized association health insurance plan" means any health
27 insurance plan, policy, or contract issued to an employer-organized association, or

1 to a trust established by one (1) or more employer-organized associations, or
2 providing coverage solely for the employees, retired employees, directors and their
3 spouses and dependents of the members of one (1) or more employer-organized
4 associations;

5 ~~(15)~~~~(14)~~ "Excepted benefits" means benefits under one (1) or more, or any combination
6 of the following:

- 7 (a) Coverage only for accident, including accidental death and dismemberment,
8 or disability income insurance, or any combination thereof;
- 9 (b) Coverage issued as a supplement to liability insurance;
- 10 (c) Liability insurance, including general liability insurance and automobile
11 liability insurance;
- 12 (d) Workers' compensation or similar insurance;
- 13 (e) Automobile medical payment insurance;
- 14 (f) Credit-only insurance;
- 15 (g) Coverage for on-site medical clinics;
- 16 (h) Other similar insurance coverage, specified in administrative regulations,
17 under which benefits for medical care are secondary or incidental to other
18 insurance benefits;
- 19 (i) Limited scope dental or vision benefits;
- 20 (j) Benefits for long-term care, nursing home care, home health care, community-
21 based care, or any combination thereof;
- 22 (k) Such other similar, limited benefits as are specified in administrative
23 regulations;
- 24 (l) Coverage only for a specified disease or illness;
- 25 (m) Hospital indemnity or other fixed indemnity insurance;
- 26 (n) Benefits offered as Medicare supplemental health insurance, as defined under
27 section 1882(g)(1) of the Social Security Act;

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

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

5 (q) Health flexible spending arrangements;

6 ~~(16)~~~~(15)~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
7 1002(32);

8 ~~(17)~~~~(16)~~ "Group health plan" means a plan, including a self-insured plan, of or
9 contributed to by an employer, including a self-employed person, or employee
10 organization, to provide health care directly or otherwise to the employees, former
11 employees, the employer, or others associated or formerly associated with the
12 employer in a business relationship, or their families;

13 ~~(18)~~~~(17)~~ "Guaranteed acceptance program participating insurer" means an insurer that
14 is required to or has agreed to offer health benefit plans in the individual market to
15 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
16 304.17A-480;

17 ~~(19)~~~~(18)~~ "Guaranteed acceptance program plan" means a health benefit plan in the
18 individual market issued by an insurer that provides health benefits to a guaranteed
19 acceptance program qualified individual and is eligible for assessment and refunds
20 under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

21 ~~(20)~~~~(19)~~ "Guaranteed acceptance program" means the Kentucky Guaranteed
22 Acceptance Program established and operated under KRS 304.17A-400 to
23 304.17A-480;

24 ~~(21)~~~~(20)~~ "Guaranteed acceptance program qualified individual" means an individual
25 who, on or before December 31, 2000:

26 (a) Is not an eligible individual;

27 (b) Is not eligible for or covered by other health benefit plan coverage or who is a

1 spouse or a dependent of an individual who:

- 2 1. Waived coverage under KRS 304.17A-210(2); or
3 2. Did not elect family coverage that was available through the association
4 or group market;

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

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

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

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

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

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

22 ~~(22)~~~~(21)~~ "Guaranteed acceptance plan supporting insurer" means either an insurer, on
23 or before December 31, 2000, that is not a guaranteed acceptance plan participating
24 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
25 guaranteed acceptance plan supporting insurer shall not include an employer-
26 sponsored self-insured health benefit plan exempted by ERISA;

27 ~~(23)~~~~(22)~~ "Health benefit plan":

- 1 (a) Shall include any:
- 2 1. Hospital or medical expense policy or certificate;
- 3 2. Nonprofit hospital, medical-surgical, and health service corporation
- 4 contract or certificate;
- 5 3. Provider sponsored integrated health delivery network;
- 6 4. Self-insured plan or a plan provided by a multiple employer welfare
- 7 arrangement, to the extent permitted by ERISA;
- 8 5. Self-insured governmental plan or church plan;
- 9 6. Health maintenance organization contract, except contracts to provide
- 10 Medicaid benefits under KRS Chapter 205; or
- 11 7. Health benefit plan that affects the rights of a Kentucky insured and
- 12 bears a reasonable relation to Kentucky, whether delivered or issued for
- 13 delivery in Kentucky; and
- 14 (b) Does not include:
- 15 1. Policies covering only accident, credit, dental, disability income, fixed
- 16 indemnity medical expense reimbursement, long-term care, Medicare
- 17 supplement, specified disease, or vision care;
- 18 2. Coverage issued as a supplement to liability insurance;
- 19 3. Insurance arising out of a workers' compensation or similar law;
- 20 4. Automobile medical-payment insurance;
- 21 5. Insurance under which benefits are payable with or without regard to
- 22 fault and that is statutorily required to be contained in any liability
- 23 insurance policy or equivalent self-insurance;
- 24 6. Short-term limited-duration coverage;
- 25 7. Student health insurance offered by a Kentucky-licensed insurer under
- 26 written contract with a university or college whose students it proposes
- 27 to insure;

- 1 8. Medical expense reimbursement policies specifically designed to fill
2 gaps in primary coverage, coinsurance, or deductibles and provided
3 under a separate policy, certificate, or contract;
- 4 9. Coverage supplemental to the coverage provided under Chapter 55 of
5 Title 10, United States Code;
- 6 10. Limited health service benefit plans;
- 7 11. Direct primary care agreements established under KRS 311.6201,
8 311.6202, 314.198, and 314.199; or
- 9 12. Coverage provided under KRS Chapter 205;

10 ~~(24)~~~~(23)~~ "Health care provider" or "provider" means any:

- 11 (a) Advanced practice registered nurse licensed under KRS Chapter 314;
- 12 (b) Chiropractor licensed under KRS Chapter 312;
- 13 (c) Dentist licensed under KRS Chapter 313;
- 14 (d) Facility or service required to be licensed under KRS Chapter 216B;
- 15 (e) Home medical equipment and services provider licensed under KRS Chapter
16 309;
- 17 (f) Optometrist licensed under KRS Chapter 320;
- 18 (g) Pharmacist licensed under KRS Chapter 315;
- 19 (h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;
- 20 (i) Physician assistant regulated under KRS Chapter 311; and
- 21 (j) Other health care practitioners as determined by the department by
22 administrative regulations promulgated under KRS Chapter 13A;

23 ~~(25)~~~~(24)~~~~(a)~~ "Health care service":

- 24 ~~(a)~~ Means health care procedures, treatments, or services rendered by a provider
25 within the scope of practice for which the provider is licensed; ~~and~~~~(-)~~
- 26 (b) ***Shall include***~~Health care service includes~~ the provision of prescription
27 drugs, as defined in KRS 315.010, and home medical equipment, as defined in

1 KRS 309.402;

2 ~~(26)~~~~(25)~~ "Health facility" or "facility" has the same meaning as in KRS 216B.015;

3 ~~(27)~~~~(26)~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
4 Program, means a covered condition in an individual policy as listed in
5 paragraph (c) of this subsection or as added by the commissioner in
6 accordance with KRS 304.17A-280, but only to the extent that the condition
7 exceeds the numerical score or rating established pursuant to uniform
8 underwriting standards prescribed by the commissioner under paragraph (b) of
9 this subsection that account for the severity of the condition and the cost
10 associated with treating that condition.

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

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

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

22 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
23 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
24 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
25 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
26 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
27 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,

1 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
2 stroke, syringomyelia, Wilson's disease, and amyotrophic lateral sclerosis;

3 (28)~~[(27)]~~ "Index rate" means, for each class of business as to a rating period, the
4 arithmetic average of the applicable base premium rate and the corresponding
5 highest premium rate;

6 (29)~~[(28)]~~ "Individual market" means the market for the health insurance coverage
7 offered to individuals other than in connection with a group health plan. The
8 individual market includes an association plan that is not employer-related, issued
9 to individuals on an individually underwritten basis, other than an employer-
10 organized association or a bona fide association;

11 (30)~~[(29)]~~ "Insurer" means any insurance company; health maintenance organization;
12 self-insurer, including a governmental plan, church plan, or multiple employer
13 welfare arrangement, not exempt from state regulation by ERISA; provider-
14 sponsored integrated health delivery network; self-insured employer-organized
15 association, or nonprofit hospital, medical-surgical, dental, or health service
16 corporation authorized to transact health insurance business in Kentucky;

17 (31)~~[(30)]~~ "Insurer-controlled" means that the commissioner has found, in an
18 administrative hearing called specifically for that purpose, that an insurer has or had
19 a substantial involvement in the organization or day-to-day operation of the entity
20 for the principal purpose of creating a device, arrangement, or scheme by which the
21 insurer segments employer groups according to their actual or anticipated health
22 status or actual or projected health insurance premiums;

23 (32)~~[(31)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001;

24 (33)~~[(32)]~~ "Large group" means:

- 25 (a) An employer with fifty-one (51) or more employees;
26 (b) An affiliated group with fifty-one (51) or more eligible members; or
27 (c) A fully insured employer-organized association as defined in subsection

1 ~~(13)~~~~(12)~~(c) or (d) of this section that:

- 2 1. Covers at least fifty-one (51) employee members; and
- 3 2. Is registered with the department pursuant to administrative regulations
- 4 promulgated by the commissioner;

5 ~~(34)~~~~(33)~~ "Managed care" means systems or techniques generally used by third-party

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

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

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

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

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

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

12 ~~(35)~~~~(34)~~ "Market segment" means the portion of the market covering one (1) of the

13 following:

- 14 (a) Individual;
- 15 (b) Small group;
- 16 (c) Large group; or
- 17 (d) Association;

18 ~~(36)~~~~(35)~~ "Medically necessary health care services" means health care services that a

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

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

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

23 ~~(37)~~~~(36)~~ "Participant" means any employee or former employee of an employer, or any

24 member or former member of an employee organization, who is or may become

25 eligible to receive a benefit of any type from an employee benefit plan which covers

26 employees of the employer or members of the organization, or whose beneficiaries

27 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

- 1 ~~(38)~~~~(37)~~ "Preventive services" means medical services for the early detection of disease
2 that are associated with substantial reduction in morbidity and mortality;
- 3 ~~(39)~~~~(38)~~ "Provider network" means an affiliated group of varied health care providers
4 that is established to provide a continuum of health care services to individuals;
- 5 ~~(40)~~~~(39)~~ "Provider-sponsored integrated health delivery network" means any provider-
6 sponsored integrated health delivery network created and qualified under KRS
7 304.17A-300 and KRS 304.17A-310;
- 8 ~~(41)~~~~(40)~~ "Purchaser" means an individual, organization, employer, association, or the
9 Commonwealth that makes health benefit purchasing decisions on behalf of a group
10 of individuals;
- 11 ~~(42)~~~~(41)~~ "Rating period" means the calendar period for which premium rates are in
12 effect. A rating period shall not be required to be a calendar year;
- 13 ~~(43)~~~~(42)~~ "Restricted provider network" means a health benefit plan that conditions the
14 payment of benefits, in whole or in part, on the use of the providers that have
15 entered into a contractual arrangement with the insurer to provide health care
16 services to covered individuals;
- 17 ~~(44)~~~~(43)~~ "Self-insured plan" means a group health insurance plan in which the
18 sponsoring organization assumes the financial risk of paying for covered services
19 provided to its enrollees;
- 20 ~~(45)~~~~(44)~~ "Small employer" means, in connection with a group health plan with respect
21 to a calendar year and a plan year, an employer who employed an average of at least
22 two (2) but not more than fifty (50) employees on business days during the
23 preceding calendar year and who employs at least two (2) employees on the first day
24 of the plan year;
- 25 ~~(46)~~~~(45)~~ "Small group" means:
- 26 (a) A small employer with two (2) to fifty (50) employees; or
27 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

1 ~~(47)~~~~(46)~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

2 ~~(48)~~~~(47)~~ "Telehealth":

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

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

14 (c) Shall be delivered over a secure communications connection that complies
15 with the federal Health Insurance Portability and Accountability Act of 1996,
16 42 U.S.C. secs. 1320d to 1320d-9.

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

19 (1) As used in this section:

20 (a) "Allowed amount" means the contractually agreed-upon amount paid by
21 an insurer to a participating provider for a health care service provided to a
22 covered person;

23 (b) "Average allowed amount" means:

24 1. The mean, median, or mode of all allowed amounts paid, within a
25 reasonable time frame not to exceed one (1) year, for a health care
26 service to:

27 a. Participating providers in the provider network of a covered

- 1 person's health benefit plan; or
- 2 b. Providers that have entered into a contract with a covered
- 3 person's insurer to provide health care services under the terms
- 4 of any health benefit plan offered by that insurer in Kentucky; or
- 5 2. Any amount determined by an insurer using an alternative calculation
- 6 method if the method is approved by the commissioner;
- 7 (c) 1. "Comparable health care service" means any nonemergency health
- 8 care service that is:
- 9 a. A covered service;
- 10 b. Provided by a participating provider that receives or agrees to
- 11 receive an allowed amount that is less than the average allowed
- 12 amount paid for the health care service; and
- 13 c. Not excluded by the commissioner pursuant to subparagraph 2.
- 14 of this paragraph.
- 15 2. The commissioner may exclude a health care service from the
- 16 definition of "comparable health care service" if an insurer can
- 17 demonstrate that the variation in allowed amounts paid for the health
- 18 care service during a reasonable time frame determined by the
- 19 commissioner is less than fifty dollars (\$50);
- 20 (d) "Covered person" means an individual entitled to receive benefits or
- 21 services under the terms of a health benefit plan;
- 22 (e) "Covered service" means a health care service available to a covered person
- 23 under the terms of the covered person's health benefit plan;
- 24 (f) "Nonemergency health care service" means a health care service that does
- 25 not involve the treatment of an emergency medical condition;
- 26 (g) "Nonparticipating provider" means a provider that has not entered into an
- 27 agreement with a covered person's insurer to provide health care services to

1 the covered person; and

2 (h) "Participating provider" means a provider that has entered into an
 3 agreement with a covered person's insurer to provide health care services to
 4 the covered person.

5 (2) (a) For all health benefit plans issued or renewed on or after the effective date
 6 of this Act, insurers shall develop and implement a program that provides
 7 incentives for covered persons who elect to receive a comparable health care
 8 service. The incentive program shall be a component of all health benefit
 9 plans offered in Kentucky.

10 (b) Incentives shall:

11 1. Be calculated:

12 a. As a percentage or flat dollar amount of the difference between
 13 the allowed amount and the average allowed amount; or

14 b. By another reasonable method approved by the commissioner;

15 2. Be at least fifty percent (50%) of the health benefit plan's saved costs
 16 for each comparable health care service received by a covered person,
 17 except a plan shall not be required to provide an incentive when the
 18 saved cost is twenty-five dollars (\$25) or less;

19 3. Be made as a:

20 a. Cash payment to the covered person;

21 b. Contribution to the covered person's health savings account; or

22 c. Credit towards the covered person's annual deductible and out-
 23 of-pocket limit; and

24 4. Not be an administrative expense for rate development or rate filing
 25 purposes.

26 (c) A health benefit plan shall, at a minimum, provide notice of the following to
 27 covered persons:

- 1 1. The availability of the incentive program and a description of the
2 incentives available;
- 3 2. How covered persons can earn incentives; and
- 4 3. That a covered person may obtain information from the interactive
5 mechanism established pursuant to subsection (3) of this section.
- 6 (d) The notices required by paragraph (c) of this subsection shall be provided:
- 7 1. On each insurer's Web site;
- 8 2. In a mobile-friendly format; and
- 9 3. In the disclosures required by Section 4 of this Act.
- 10 (e) 1. Unless otherwise permitted pursuant to subparagraph 2. of this
11 paragraph, an insurer shall file with the department, for each health
12 benefit plan, the following information for the most recent calendar
13 year:
- 14 a. The total number and amount of incentives provided to covered
15 persons pursuant to this subsection;
- 16 b. The total number and percentage of covered persons that
17 received a comparable health care service; and
- 18 c. By category of service:
- 19 i. The total number of comparable health care services used
20 for which incentives were provided;
- 21 ii. The average amount of incentives provided; and
- 22 iii. The total savings achieved.
- 23 2. The commissioner may set reasonable limits on the reporting required
24 by this paragraph to focus on the more popular comparable health
25 care services.
- 26 (f) By June 1, 2023, and by June 1 of each year thereafter, the department
27 shall submit an aggregate report of the data received pursuant to paragraph

1 (e) of this subsection to the Interim Joint Committee on Banking and
2 Insurance.

3 (3) (a) For all health benefit plans issued or renewed on or after the effective date
4 of this Act, insurers shall establish an interactive mechanism on a publicly
5 accessible Web site that enables covered persons to obtain:

6 1. For each participating provider:

7 a. The allowed amount, including any facility fees, paid for each
8 comparable health care service provided by that participating
9 provider;

10 b. The allowed amount, including any facility fees, paid for any
11 nonemergency health care service that is a covered service
12 provided by that participating provider; and

13 c. To the extent available, quality data for that participating
14 provider;

15 2. The average allowed amount for any nonemergency health care
16 service that is a covered service; and

17 3. A good-faith estimate of the out-of-pocket costs applicable to the
18 covered person for a nonemergency health care service that is a
19 covered service, including but not limited to any copayment,
20 deductible, or coinsurance.

21 (b) To the extent consistent with federal law, the good-faith estimate required
22 by paragraph (a)3. of this subsection:

23 1. Shall be based on information available to the insurer at the time the
24 request is made;

25 2. May be provided by a third-party vendor contracted to provide the
26 estimate;

27 3. Shall also be available to the covered person through a toll-free

1 telephone number;

2 4. Shall not prohibit the health benefit plan from imposing cost-sharing
3 requirements disclosed in the plan for unforeseen health care services
4 that arise out of a nonemergency health care service or for a health
5 care service that was not included in the original estimate; and

6 5. Shall include a notification to the covered person that the costs
7 disclosed are an estimate and that the actual amount the covered
8 person is responsible for paying may vary from the original estimate
9 due to unforeseen health care services that arise out of a
10 nonemergency health care service.

11 (4) (a) All health benefit plans issued or renewed on or after the effective date of
12 this Act shall provide coverage as set forth in paragraph (b) of this
13 subsection for each nonemergency health care service that is:

14 1. A covered service; and

15 2. Provided by a nonparticipating provider to a covered person, if the
16 price of the health care service is the same or less than the average
17 allowed amount for that health care service.

18 (b) 1. The insurer shall pay the nonparticipating provider's price less any in-
19 network out-of-pocket costs, including but not limited to any
20 copayment, deductible, or coinsurance, that would be owed by the
21 covered person if the health care service was provided by a
22 participating provider.

23 2. The insurer shall apply any payment made by the covered person for
24 the health care service provided by the nonparticipating provider
25 towards any annual in-network deductible for the covered person and
26 any annual limit on the covered person's out-of-pocket costs.

27 (c) For each health benefit plan, insurers shall:

1 1. Provide a downloadable or interactive online form to the covered
 2 person for any proof of payment that may be required to demonstrate
 3 compliance with this subsection; and

4 2. Inform covered persons of their options under this subsection both on
 5 the insurer's Web site and in the disclosures required under Section 4
 6 of this Act.

7 (5) In addition to the requirements of this section, for all health benefit plans issued
 8 or renewed on or after the effective date of this Act, insurers shall comply with
 9 the following federal regulations, as in effect on January 1, 2021, including any
 10 subsequent compliance dates set forth in those regulations:

11 (a) 26 C.F.R. secs. 54.9815-2715A1, 54.9815-2715A2, and 54.9815-2715A3;

12 (b) 29 C.F.R. secs. 2590.715-2715A1, 2590.715-2715A2, and 2590.715-2715A3;

13 and

14 (c) 45 C.F.R. secs. 147.210, 147.211, and 147.212.

15 (6) This section shall be in addition to, and shall not be construed to limit, any other
 16 state or federal law that establishes coverage and other requirements for health
 17 benefit plans and insurers.

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

19 An insurer that offers a health benefit plan that is not a managed care plan as defined in
 20 Section 8 of this Act, but that provides financial incentives for a covered person to access
 21 a network of providers shall:

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

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

- 1 professional office address, telephone number, and specialty designations of
2 the network provider, if any; and
- 3 (b) In addition to making the information available in a printed document, an
4 insurer may also make the information available in an accessible electronic
5 format;
- 6 (2) Assure that contracts with the providers in the network contain a hold harmless
7 agreement under which the covered person ~~shall~~~~will~~ not be balanced billed by the
8 in-network provider except for deductibles, co-pays, coinsurance amounts, and
9 noncovered benefits;
- 10 (3) File with the department:
- 11 (a) A copy of the directory required under subsection (1) of this section; and
12 (b) *A description of the incentive program required by subsection (2) of Section*
13 *2 of this Act. The filing shall be made prior to offering the program to any*
14 *covered person and in a manner and form prescribed by the commissioner.*
15 *The filing, and any supporting documentation, shall be confidential until it*
16 *is approved or disapproved by the commissioner;*
- 17 (4) Have a process for the selection of health care providers who will be on the insurer's
18 list of participating providers, with written policies and procedures for review and
19 approval used by the insurer. The insurer shall establish minimum professional
20 requirements for participating health care providers. An insurer ~~shall~~~~may~~ not
21 discriminate against a provider solely on the basis of the provider's license by the
22 state;
- 23 (5) Not contract with a health care provider to limit the provider's disclosure to a
24 covered person, or to another person on behalf of a covered person, of any
25 information relating to the covered person's medical condition or treatment options;
- 26 (6) Not penalize a health care provider, or terminate a health care provider's contract
27 with the insurer, because the provider discusses medically necessary or appropriate

1 care with a covered person or another person on behalf of a covered person. The
 2 health care provider may:

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

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

8 (7) Include ***the following clauses*** in any agreements it enters into with providers for the
 9 provision of health care services ~~:[a clause stating]~~

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

18 ***(b) The following shall comply with the provisions of 45 C.F.R. Part 180, as***
 19 ***finalized on November 27, 2019:***

20 ***1. Hospitals subject to the requirements of 45 C.F.R. Part 180, as***
 21 ***finalized on November 27, 2019; and***

22 ***2. All other providers, including hospitals not subject to subparagraph 1.***
 23 ***of this paragraph, except providers that receive ninety percent (90%)***
 24 ***or more of their reimbursements for health care services from publicly***
 25 ***funded assistance or insurance programs, such as Medicaid and***
 26 ***Medicare;***

27 ***(c) 1. Within seventy-two (72) hours of a covered person making an***

- 1 appointment for nonemergency health care services, or if the
2 appointment is within seventy-two (72) hours, then as soon as possible
3 but not later than the time of appointment, the provider shall provide
4 each covered person with written notice of the following:
- 5 a. The amount the provider expects to be paid for the health care
6 services from the insurer;
- 7 b. An estimate of the covered person's out-of-pocket costs for the
8 health care services. If an estimate is not available to the
9 provider, the provider shall notify the covered person that the
10 person may obtain that information from the insurer; and
- 11 c. The amount the provider would accept in cash for the health
12 care services.
- 13 2. If the provider is not able to comply with the requirements of this
14 paragraph due to the provider's inability to predict the health care
15 service or diagnostic code for the health care service that is to be
16 recommended or provided to the covered person, the health care
17 provider shall disclose what is known about the proposed
18 nonemergency health care service within the time required, including
19 any facility fees that may be required by a facility at which the
20 provider proposes to provide the nonemergency health care service.
21 The provider shall also disclose the incomplete nature of the
22 information provided to the covered person and inform the covered
23 person of the person's ability to obtain updated information from the
24 provider once additional information is obtained by the provider; and
- 25 (d) The health care provider shall comply with subsection (4) of Section 6
26 of this Act;

- 27 (8) Establish a policy governing the removal of and withdrawal by health care providers

1 from the provider network that includes the following:

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

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

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

14 (9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS
15 304.17A-700 to 304.17A-730.

16 ➔Section 4. KRS 304.17A-505 is amended to read as follows:

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

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

25 (a) Covered services and benefits to which the ~~enrollee or other~~ covered person
26 is entitled, **including the notices to covered persons that are required under**
27 **Section 2 of this Act;**

- 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 a
19 covered person~~[an 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 a covered person~~[an insured or~~
26 ~~enrollee]~~, a complete drug formulary; and
- 27 (k) A statement informing the covered person~~[insured or enrollee]~~ that if the

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

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

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

7 (1) **An insurer that offers** a managed care plan shall file with the commissioner sample
 8 copies of any agreements it enters into with providers for the provision of health
 9 care services. The commissioner shall promulgate administrative regulations
 10 prescribing the manner and form of the filings required. The agreements shall
 11 include the following:

12 (a) A hold harmless clause that states that the provider ~~shall~~^{may} not, under any
 13 circumstance, including:

- 14 1. Nonpayment of moneys due the providers by the managed care plan,
- 15 2. Insolvency of the managed care plan, or
- 16 3. Breach of the agreement,

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

23 (b) A continuity of care clause that states that if an agreement between the
 24 provider and the managed care plan is terminated for any reason, other than a
 25 quality of care issue or fraud, the insurer shall continue to provide services
 26 and ~~the plan shall continue to~~ reimburse the provider in accordance with the
 27 agreement until the ~~subscriber, dependent of the subscriber, or the~~ enrollee is

1 discharged from an inpatient facility, or the active course of treatment is
2 completed, whichever time is greater, and in the case of a pregnant woman,
3 services shall continue to be provided through the end of the post-partum
4 period if the pregnant woman is in her fourth or later month of pregnancy at
5 the time the agreement is terminated;

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

9 (d) A clause stating that the insurer~~[issuing a managed care plan]~~ **shall**~~[will]~~,
10 upon request of a participating provider, provide or make available to a
11 participating provider, when contracting or renewing an existing contract with
12 such provider, the payment or fee schedules or other information sufficient to
13 enable the provider to determine the manner and amount of payments under
14 the contract for the provider's services prior to the final execution or renewal
15 of the contract and shall provide any change in such schedules at least ninety
16 (90) days prior to the effective date of the amendment pursuant to KRS
17 304.17A-577;~~[and]~~

18 (e) A clause requiring that if a provider enters into any subcontract agreement
19 with another provider to provide~~[their licensed]~~ health care services to the~~[~~
20 ~~subscriber, dependent of the subscriber, or]~~ enrollee of a managed care plan
21 where the subcontracted provider will bill the managed care plan or~~[~~
22 ~~subscriber or]~~ enrollee directly for the subcontracted services, the subcontract
23 agreement **shall**~~[must]~~ meet all requirements of this subtitle and that all~~[such]~~
24 subcontract agreements shall be filed with the commissioner in accordance
25 with this subsection; **and**

26 **(f) The clauses required by subsection (7)(b), (c), and (d) of Section 3 of this**
27 **Act.**

1 (2) An insurer that offers a managed care plan shall file with the department a
2 description of the incentive program required by subsection (2) of Section 2 of
3 this Act. The filing shall be made prior to offering the program to any enrollee
4 and in a manner and form prescribed by the commissioner. The filing, and any
5 supporting documentation, shall be confidential until it is approved or
6 disapproved by the commissioner.

7 ~~(3)(2)~~ An insurer that offers a health benefit plan that enters into any risk-sharing
8 arrangement or subcontract agreement shall file a copy of the arrangement with the
9 commissioner. The insurer shall also file the following information regarding the
10 risk-sharing arrangement:

- 11 (a) The number of enrollees affected by the risk-sharing arrangement;
- 12 (b) The health care services to be provided to an enrollee under the risk-sharing
13 arrangement;
- 14 (c) The nature of the financial risk to be shared between the insurer and entity or
15 provider, including but not limited to the method of compensation;
- 16 (d) Any administrative functions delegated by the insurer to the entity or provider.
17 The insurer shall describe a plan to ensure that the entity or provider will
18 comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated
19 administrative functions; and
- 20 (e) The insurer's oversight and compliance plan regarding the standards and
21 method of review.

22 ~~(4)(3)~~ Nothing in this section shall be construed as requiring an insurer to submit the
23 actual financial information agreed to between the insurer and the entity or provider.
24 The commissioner shall have access to a specific risk sharing arrangement with an
25 entity or provider upon request to the insurer. Financial information obtained by the
26 department shall be considered to be a trade secret and shall not be subject to KRS
27 61.872 to 61.884.

1 ➔SECTION 6. A NEW SECTION OF KRS CHAPTER 367 IS CREATED TO
2 READ AS FOLLOWS:

3 (1) As used in this section:

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

5 1. "Health care provider" or "provider";

6 2. "Health care service"; and

7 3. "Insurer"; and

8 (b) The following have the same meaning as in Section 2 of this Act:

9 1. "Allowed amount";

10 2. "Covered person";

11 3. "Nonemergency health care service"; and

12 4. "Nonparticipating provider".

13 (2) (a) Upon request by a covered person who is a patient or a prospective patient
14 of a nonparticipating provider, the nonparticipating provider shall disclose
15 to the covered person the price that will be collected for a proposed
16 nonemergency health care service, including any facility fees that may be
17 required by a facility at which the nonparticipating provider proposes to
18 provide the nonemergency health care service.

19 (b) Except as otherwise provided in subsection (3) of this section, the disclosure
20 required by paragraph (a) of this subsection shall be made within seventy-
21 two (72) hours of the covered person's request and prior to the provision of
22 a nonemergency health care service to the covered person.

23 (3) If the nonparticipating provider is not able to comply with the requirements set
24 forth in subsection (2)(b) of this section due to the nonparticipating provider's
25 inability to predict the health care service or diagnostic code for the health care
26 service that is to be recommended or provided to the covered person, the
27 nonparticipating provider shall disclose what is known about the proposed

1 nonemergency health care service within the time required, including any facility
2 fees that may be required by a facility at which the nonparticipating provider
3 proposes to provide the nonemergency health care service. The nonparticipating
4 provider shall also disclose the incomplete nature of the information provided to
5 the covered person and inform the covered person of the person's ability to obtain
6 updated information from the nonparticipating provider once additional
7 information is obtained by the provider.

8 (4) (a) Health care providers shall post in an area that is visible to the provider's
9 patients and prospective patients the following notifications:

10 1. That covered persons may obtain sufficient information from the
11 provider about nonemergency health care services recommended or
12 provided by the provider to allow the covered person to receive
13 assistance from the covered person's insurer in comparing out-of-
14 pocket and allowed amounts paid for the covered person's health care
15 to different health care providers for similar services;

16 2. That, for each health care service being recommended or provided, the
17 following information may be obtained from the provider pursuant to
18 subparagraph 1. of this paragraph:

19 a. A common procedural terminology code or other coding system
20 commonly used by the health care provider and accepted as a
21 national standard for billing; and

22 b. A plain language description of the health care service;

23 3. That covered persons may obtain health care services from different
24 providers regardless of a referral or recommendation from a provider;

25 4. That seeing a high-value provider, either their currently referred
26 provider or a different provider, may result in an incentive payment to
27 the covered person if the person follows the procedures communicated

- 1 by the person's insurer;
- 2 5. An outline of the potential incentives authorized by Section 2 of this
- 3 Act;
- 4 6. That the covered person's insurer is required to provide the person an
- 5 estimate of out-of-pocket costs and allowed amounts paid for the
- 6 person's care to different providers for similar services via a Web site,
- 7 in a mobile-friendly format, and a toll-free telephone number; and
- 8 7. Any other information that is necessary to inform covered persons of
- 9 the price transparency tools required by Section 2 of this Act.
- 10 (b) The commissioner of insurance may promulgate administrative regulations
- 11 to implement this subsection.

➔Section 7. KRS 304.17A-096 is amended to read as follows:

- 13 (1) An insurer authorized to engage in the business of insurance in the Commonwealth
- 14 of Kentucky may offer one (1) or more basic health benefit plans in the individual,
- 15 small group, and employer-organized association markets. A basic health benefit
- 16 plan shall cover physician, pharmacy, home health, preventive, emergency, and
- 17 inpatient and outpatient hospital services in accordance with the requirements of
- 18 this subtitle. If vision or eye services are offered, these services may be provided by
- 19 an ophthalmologist or optometrist.
- 20 (2) An insurer that offers a basic health benefit plan shall be required to offer health
- 21 benefit plans as defined in KRS 304.17A-005~~[(22)]~~.
- 22 (3) An insurer in the individual, small group, or employer-organized association
- 23 markets that offers a basic health benefit plan may offer a basic health benefit plan
- 24 that excludes from coverage any state-mandated health insurance benefit, except
- 25 that the basic health benefit plan shall include coverage for diabetes as provided in
- 26 KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic
- 27 benefits as provided in KRS 304.17A-171, mammograms as provided in KRS

1 304.17A-133, and those mandated benefits specified under federal law.

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

5 ➔Section 8. KRS 304.17A-500 is amended to read as follows:

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

- 7 (1) "Areas other than urban areas" means a classification code that does not meet the
8 definition of urban area;
- 9 (2) "Contract holder" means an employer or organization that purchases a health benefit
10 plan;
- 11 (3) "Covered person" means a person on whose behalf an insurer offering the plan is
12 obligated to pay benefits or provide services under the health insurance policy;
- 13 (4) ~~["Emergency medical condition" means:~~
- 14 ~~(a) A medical condition manifesting itself by acute symptoms of sufficient~~
15 ~~severity, including severe pain, that a prudent layperson would reasonably~~
16 ~~have cause to believe constitutes a condition that the absence of immediate~~
17 ~~medical attention could reasonably be expected to result in:~~
- 18 ~~1. Placing the health of the individual or, with respect to a pregnant~~
19 ~~woman, the health of the woman or her unborn child, in serious~~
20 ~~jeopardy;~~
- 21 ~~2. Serious impairment to bodily functions; or~~
- 22 ~~3. Serious dysfunction of any bodily organ or part; or~~
- 23 ~~(b) With respect to a pregnant woman who is having contractions:~~
- 24 ~~1. A situation in which there is inadequate time to effect a safe transfer to~~
25 ~~another hospital before delivery; or~~
- 26 ~~2. A situation in which transfer may pose a threat to the health or safety of~~
27 ~~the woman or the unborn child;~~

- 1 ~~(5)~~ "Enrollee" means a person who is enrolled in a plan offered by a health maintenance
2 organization as defined in KRS 304.38-030(5);
- 3 ~~(5)~~~~(6)~~ "Grievance" means a written complaint submitted by or on behalf of an
4 enrollee;
- 5 ~~(6)~~~~(7)~~ "Health insurance policy" means "health benefit plan" as defined in KRS
6 304.17A-005;
- 7 ~~(8)~~ "Insurer" has the meaning provided in KRS 304.17A-005.;
- 8 ~~(7)~~~~(9)~~ "Managed care plan" means a health insurance policy that integrates the
9 financing and delivery of appropriate health care services to enrollees by
10 arrangements with participating providers who are selected to participate on the
11 basis of explicit standards to furnish a comprehensive set of health care services and
12 financial incentives for enrollees to use the participating providers and procedures
13 provided for in the plan;
- 14 ~~(8)~~~~(10)~~ "Participating health care provider" means a health care provider that has
15 entered into an agreement with an insurer to provide health care services;
- 16 ~~(9)~~~~(11)~~ "Quality assurance or improvement" means the ongoing evaluation by a
17 managed care plan of the quality of health care services provided to its enrollees;
- 18 ~~(10)~~~~(12)~~ "Record" means any written, printed, or electronically recorded material
19 maintained by a provider in the course of providing health services to a patient
20 concerning the patient and the services provided. "Record" also includes the
21 substance of any communication made by a patient to a provider in confidence
22 during or in connection with the provision of health services to a patient or
23 information otherwise acquired by the provider about a patient in confidence and in
24 connection with the provision of health services to a patient;
- 25 ~~(11)~~~~(13)~~ "Risk sharing arrangement" means any agreement that allows an insurer to
26 share the financial risk of providing health care services to enrollees or insureds
27 with another entity or provider where there is a chance of financial loss to the entity

1 or provider as a result of the delivery of a service. A risk sharing arrangement shall
 2 not include a reinsurance contract with an accredited or admitted reinsurer;

3 ~~(12)~~~~(14)~~ "Urban area" means a classification code whereby the zip code population
 4 density is greater than three thousand (3,000) persons per square mile; and

5 ~~(13)~~~~(15)~~ "Utilization management" means a system for reviewing the appropriate and
 6 efficient allocation of health care services under a health benefits plan according to
 7 specified guidelines, in order to recommend or determine whether, or to what
 8 extent, a health care service given or proposed to be given to a covered person
 9 should or will be reimbursed, covered, paid for, or otherwise provided under the
 10 plan. The system may include preadmission certification, the application of practice
 11 guidelines, continued stay review, discharge planning, preauthorization of
 12 ambulatory care procedures, and retrospective review.

13 ➔Section 9. KRS 304.17A-550 is amended to read as follows:

14 (1) (a) An insurer that offers a managed care plan shall offer a health benefit plan
 15 with out-of-network benefits to every contract holder. The plan with out-of-
 16 network benefits shall allow a covered person to receive covered services
 17 from out-of-network health care providers without having to obtain a referral.

18 (b) Except as provided in Section 2 of this Act, the plan with out-of-network
 19 benefits may require that an enrollee pre-certify selected services and pay a
 20 higher deductible, copayment, coinsurance, excess charges and higher
 21 premium for the out-of-network benefit plan pursuant to limits established by
 22 administrative regulations promulgated by the department.

23 (2) If the contract holder elects the out-of-network offering required under subsection
 24 (1) of this section, the insurer shall provide each enrollee with the opportunity at the
 25 time of enrollment and during the annual open enrollment period, to enroll in the
 26 out-of-network option. If the contract holder elects the out-of-network offering
 27 required under subsection (1) of this section, the insurer and the contract holder

1 shall provide written notice of the benefit plan with out-of-network benefits to each
2 enrollee in a plan and shall include in that notice a detailed explanation of the
3 financial costs to be incurred by an enrollee who selects the plan.

4 (3) The requirement of this section shall not apply to an insurer contract which offers a
5 managed care plan that provides health care services solely to Medicaid or Medicare
6 recipients.

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

10 ➔Section 10. KRS 304.17A-580 is amended to read as follows:

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

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

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

26 (4) Nothing in this section shall apply to accident-only, specified disease, hospital
27 indemnity, Medicare supplement, long-term care, disability income, or other

1 limited-benefit health insurance policies.

2 ➔Section 11. KRS 304.17A-649 is amended to read as follows:

3 The commissioner shall promulgate administrative regulations necessary to implement
4 the provisions of KRS ~~{304.17A-640,}~~ 304.17A-641, 304.17A-643, 304.17A-645, and
5 304.17A-647.

6 ➔Section 12. KRS 304.17B-001 is amended to read as follows:

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

- 8 (1) "Administrator" is defined in KRS 304.9-051~~{(1)}~~;
- 9 (2) "Agent" is defined in KRS 304.9-020;
- 10 (3) "Assessment process" means the process of assessing and allocating guaranteed
11 acceptance program losses or Kentucky Access funding as provided for in KRS
12 304.17B-021;
- 13 (4) "Authority" means the Kentucky Health Care Improvement Authority;
- 14 (5) "Case management" means a process for identifying an enrollee with specific health
15 care needs and interacting with the enrollee and their respective health care
16 providers in order to facilitate the development and implementation of a plan that
17 efficiently uses health care resources to achieve optimum health outcome;
- 18 ~~(6) {"Commissioner" is defined in KRS 304.1-050(1);~~
- 19 ~~(7) {"Department" is defined in KRS 304.1-050(2);~~
- 20 ~~(8)}~~ "Earned premium" means the portion of premium paid by an insured that has been
21 allocated to the insurer's loss experience, expenses, and profit year to date;
- 22 ~~(7)}~~(9) "Enrollee" means a person who is enrolled in a health benefit plan offered
23 under Kentucky Access;
- 24 ~~(8)}~~(10) "Eligible individual" is defined in KRS 304.17A-005~~{(11)}~~;
- 25 ~~(9)}~~(11) "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed
26 Acceptance Program established and operated under KRS 304.17A-400 to
27 304.17A-480;

- 1 ~~(10)~~~~(12)~~ "Guaranteed acceptance program participating insurer" means an insurer that
2 offered health benefit plans through December 31, 2000, in the individual market to
3 guaranteed acceptance program qualified individuals;
- 4 ~~(11)~~~~(13)~~ "Health benefit plan" is defined in KRS 304.17A-005~~(22)~~;
- 5 ~~(12)~~~~(14)~~ "High-cost condition" means acquired immune deficiency syndrome (AIDS),
6 angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary
7 insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia,
8 Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic
9 cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy,
10 myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic
11 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease,
12 chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the
13 bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short
14 gestation period for a newborn child, and low birth weight of a newborn child;
- 15 ~~(13)~~~~(15)~~ "Incurred losses" means for Kentucky Access the excess of claims paid over
16 premiums received;
- 17 ~~(14)~~~~(16)~~ "Insurer" is defined in KRS 304.17A-005~~(29)~~;
- 18 ~~(15)~~~~(17)~~ "Kentucky Access" means the program established in accordance with KRS
19 304.17B-001 to 304.17B-031;
- 20 ~~(16)~~~~(18)~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;
- 21 ~~(17)~~~~(19)~~ "Kentucky Health Care Improvement Authority" means the board established
22 to administer the program initiatives listed in KRS 304.17B-003(5);
- 23 ~~(18)~~~~(20)~~ "Kentucky Health Care Improvement Fund" means the fund established for
24 receipt of the Kentucky tobacco master settlement moneys for program initiatives
25 listed in KRS 304.17B-003(5);
- 26 ~~(19)~~~~(21)~~ "MARS" means the Management Administrative Reporting System
27 administered by the Commonwealth;

1 ~~(20)~~~~(22)~~ "Medicaid" means coverage in accordance with Title XIX of the Social
2 Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

3 ~~(21)~~~~(23)~~ "Medicare" means coverage under both Parts A and B of Title XVIII of the
4 Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

5 ~~(22)~~~~(24)~~ "Office" means the Office of Health Data and Analytics in the Cabinet for
6 Health and Family Services;

7 ~~(23)~~~~(25)~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~(6)~~;

8 ~~(24)~~~~(26)~~ "Standard health benefit plan" means a health benefit plan that meets the
9 requirements of KRS 304.17A-250;

10 ~~(25)~~~~(27)~~ "Stop-loss carrier" means any person providing stop-loss health insurance
11 coverage;

12 ~~(26)~~~~(28)~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured
13 employer-controlled or bona fide associations; and

14 ~~(27)~~~~(29)~~ "Utilization management" is defined in KRS 304.17A-500~~(12)~~.

15 ➔Section 13. KRS 304.17B-015 is amended to read as follows:

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

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

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

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

- 1 (c) The individual has a high-cost condition listed in KRS 304.17B-001.
- 2 (3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year
3 period shall be issued a notice of insurability. The notice shall indicate that the
4 Kentucky Access enrollee has not had claims exceed premium rates for a three (3)
5 year period and may be used by the enrollee to obtain insurance in the regular
6 individual market.
- 7 (4) An individual shall not be eligible for coverage under Kentucky Access if:
- 8 (a) 1. The individual has, or is eligible for, on the effective date of coverage
9 under Kentucky Access, substantially similar coverage under another
10 contract or policy, unless the individual was issued coverage from a
11 GAP participating insurer as a GAP qualified individual prior to January
12 1, 2001. A GAP qualified individual shall be automatically eligible for
13 coverage under Kentucky Access without regard to the requirements of
14 subsection (2) of this section; or
- 15 2. For eligible individuals as defined in ~~meeting the requirements of~~ KRS
16 304.17A-005~~[(11)]~~, the individual has, or is eligible for, on the effective
17 date of coverage under Kentucky Access, coverage under a group health
18 plan.
- 19 An individual who is ineligible for coverage pursuant to this paragraph shall
20 not preclude the individual's spouse or dependents from being eligible for
21 Kentucky Access coverage. As used in this paragraph, "eligible for" includes
22 any individual and an individual's spouse or dependent who was eligible for
23 coverage but waived that coverage. That individual and the individual's
24 spouse or dependent shall be ineligible for Kentucky Access coverage through
25 the period of waived coverage;
- 26 (b) The individual is eligible for coverage under Medicaid or Medicare;
- 27 (c) The individual previously terminated Kentucky Access coverage and twelve

- 1 (12) months have not elapsed since the coverage was terminated, unless the
2 individual demonstrates a good faith reason for the termination;
- 3 (d) Except for covered benefits paid under the standard health benefit plan as
4 specified in KRS 304.17B-019, Kentucky Access has paid two million dollars
5 (\$2,000,000) in covered benefits per individual. The maximum limit under
6 this paragraph may be increased by the office;
- 7 (e) The individual is confined to a public institution or incarcerated in a federal,
8 state, or local penal institution or in the custody of federal, state, or local law
9 enforcement authorities, including work release programs; or
- 10 (f) The individual's premium, deductible, coinsurance, or copayment is partially
11 or entirely paid or reimbursed by an individual or entity other than the
12 individual or the individual's parent, grandparent, spouse, child, stepchild,
13 father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-
14 law, sister-in-law, grandchild, guardian, or court-appointed payor.
- 15 (5) The coverage of any person who ceases to meet the requirements of this section or
16 the requirements of any administrative regulation promulgated under this subtitle
17 may be terminated.
- 18 ➔Section 14. KRS 304.17B-033 is amended to read as follows:
- 19 (1) No less than annually, the Health Insurance Advisory Council shall review the list
20 of high-cost conditions established under KRS 304.17B-001~~-(14)}~~ and recommend
21 changes to the director of the Division of Health Benefit Exchange. The director
22 may accept or reject any or all of the recommendations and may make whatever
23 changes by administrative regulation the director deems appropriate. The council, in
24 making recommendations, and the director, in making changes, shall consider,
25 among other things, actual claims and losses on each diagnosis and advances in
26 treatment of high-cost conditions.
- 27 (2) The director may by administrative regulation add to or delete from the list of high-

1 cost conditions for Kentucky Access.

2 ➔Section 15. KRS 304.17C-010 is amended to read as follows:

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

- 4 (1) "At the time of enrollment" means the same as defined in KRS 304.17A-005~~[(2)]~~;
- 5 (2) "Enrollee" means an individual who is enrolled in a limited health service benefit
6 plan;
- 7 (3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-
8 005~~[(23)]~~;
- 9 (4) "Insurer" means any insurance company, health maintenance organization, self-
10 insurer or multiple employer welfare arrangement not exempt from state regulation
11 by ERISA, provider-sponsored integrated health delivery network, self-insured
12 employer-organized association, nonprofit hospital, medical-surgical, dental, health
13 service corporation, or limited health service organization authorized to transact
14 health insurance business in Kentucky who offers a limited health service benefit
15 plan; and
- 16 (5) "Limited health service benefit plan" means any policy or certificate that provides
17 services for dental, vision, mental health, substance abuse, chiropractic,
18 pharmaceutical, podiatric, or other such services as may be determined by the
19 commissioner to be offered under a limited health service benefit plan. A limited
20 health service benefit plan shall not include hospital, medical, surgical, or
21 emergency services except as these services are provided incidental to the plan.

22 ➔Section 16. KRS 304.38A-010 is amended to read as follows:

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

- 24 (1) "Enrollee" means an individual who is enrolled in a limited health services benefit
25 plan;
- 26 (2) "Evidence of coverage" means any certificate, agreement, contract, or other
27 document issued to an enrollee stating the limited health services to which the

1 enrollee is entitled. All coverages described in an evidence of coverage issued by a
 2 limited health service organization are deemed to be "limited health services benefit
 3 plans" to the extent defined in KRS 304.17C-010 unless exempted by the
 4 commissioner;

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

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

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

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

20 ➔Section 17. KRS 304.39-241 is amended to read as follows:

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

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

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

- 1 (3) Medicaid;
- 2 (4) Medicare; or
- 3 (5) A Medicare supplement provider.

4 ➔Section 18. KRS 304.17A-0954 is amended to read as follows:

- 5 (1) Notwithstanding any other provision of this chapter, the amount or rate of
6 premiums for an employer-organized association health plan may be determined,
7 subject to the restrictions of subsection (2) of this section, based upon the
8 experience or projected experience of the employer-organized associations whose
9 employers obtain group coverage under the plan.
- 10 (2) The following restrictions shall be applied in calculating the permissible amount or
11 rate of premiums for an employer-organized association health insurance plan
12 issued to an employer-organized association as defined in KRS 304.17A-
13 005(~~13~~)(~~12~~)(a) to (c):
 - 14 (a) The premium rates charged during a rating period to members of the
15 employer-organized association with similar characteristics for the same or
16 similar coverage, or the premium rates that could be charged to a member of
17 the employer-organized association under the rating system for that class of
18 business, shall not vary from its own index rate by more than fifty percent
19 (50%) of its own index rate;
 - 20 (b) The percentage increase in the premium rate charged to an employer member
21 of an employer-organized association for a new rating period shall not exceed
22 the sum of the following:
 - 23 1. The percentage change in the new business premium rate for the
24 employer-organized association measured from the first day of the prior
25 rating period to the first day of the new rating period;
 - 26 2. Any adjustment, not to exceed twenty percent (20%) annually and
27 adjusted pro rata for rating period of less than one (1) year, due to the

1 claims experience, mental and physical condition, including medical
2 condition, medical history, and health service utilization, or duration of
3 coverage of the member as determined from the insurer's rate manual;
4 and

5 3. Any adjustment due to change in coverage or change in the case
6 characteristics of the member as determined by the insurer's rate manual;

7 (c) In utilizing case characteristics, the ratio of the highest rate factor to the
8 lowest rate factor within a class of business shall not exceed five to one (5:1).
9 For purpose of this limitation, case characteristics include age, gender,
10 occupation or industry, and geographic area; and

11 (d) Unless the written consent of the employer-organized association is filed with
12 the department, the index rate for the employer-organized association shall be
13 calculated solely with respect to that employer-organized association and shall
14 not be tied to, linked to, or otherwise adversely affected by any other index
15 rate used by the issuing insurer.

16 (3) For the purpose of this section, a health insurance contract that utilizes a restricted
17 provider network shall not be considered similar coverage to a health insurance
18 contract that does not utilize a restricted provider network if utilization of the
19 restricted provider network results in measurable differences in claims costs.

20 ➔Section 19. The following KRS section is repealed:

21 304.17A-640 Definitions for KRS 304.17A-640 et seq.

22 ➔Section 20. If any provision of this Act, or this Act's application to any person
23 or circumstance, is held invalid, the invalidity shall not affect other provisions or
24 applications of the Act, which shall be given effect without the invalid provision or
25 application, and to this end the provisions and applications of this Act are severable.

26 ➔Section 21. This Act takes effect on January 1, 2022.