

1 AN ACT relating to surprise billing.

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

3 ➔Section 1. KRS 304.17A-005 (Effective January 1, 2020) is amended to read as
4 follows:

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

6 (1) "Association" means an entity, other than an employer-organized association, that
7 has been organized and is maintained in good faith for purposes other than that of
8 obtaining insurance for its members and that has a constitution and bylaws;

9 (2) "At the time of enrollment" means:

10 (a) At the time of application for an individual, an association that actively
11 markets to individual members, and an employer-organized association that
12 actively markets to individual members; and

13 (b) During the time of open enrollment or during an insured's initial or special
14 enrollment periods for group health insurance;

15 (3) **"Balance bill" or "balance billing" means a provider billing a covered person for**
16 **the remaining balance of the amount the provider charges for a service less the**
17 **following:**

18 **(a) The amount an insurer reimburses for the service; and**

19 **(b) Any applicable cost-sharing the covered person is required to pay;**

20 **(4)** "Base premium rate" means, for each class of business as to a rating period, the
21 lowest premium rate charged or that could have been charged under the rating
22 system for that class of business by the insurer to the individual or small group, or
23 employer as defined in KRS 304.17A-0954, with similar case characteristics for
24 health benefit plans with the same or similar coverage;

25 **(5)**~~**(4)**~~ "Basic health benefit plan" means any plan offered to an individual, a small
26 group, or employer-organized association that limits coverage to physician,
27 pharmacy, home health, preventive, emergency, and inpatient and outpatient

1 hospital services in accordance with the requirements of this subtitle. If vision or
2 eye services are offered, these services may be provided by an ophthalmologist or
3 optometrist. Chiropractic benefits may be offered by providers licensed pursuant to
4 KRS Chapter 312;

5 ~~(6)~~~~(5)~~ "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
6 91(d)(3);

7 ~~(7)~~~~(6)~~ "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

8 ~~(8)~~~~(7)~~ "COBRA" means any of the following:

- 9 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
10 vaccines;
- 11 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
12 et seq. other than sec. 1169); or
- 13 (c) 42 U.S.C. sec. 300bb;

14 ~~(9)~~ "Cost-sharing":

15 ~~(a)~~ Means any expenditure required to be paid by or on behalf of a covered
16 person with respect to receiving benefits or services under a health
17 insurance plan or policy, including a health benefit plan;

18 ~~(b)~~ Includes coinsurance, deductibles, and copayments; and

19 ~~(c)~~ Does not include premiums, balance billings from nonparticipating
20 providers, or spending for noncovered services;

21 ~~(10)~~~~(8)~~ "Creditable coverage":

- 22 (a) Means, with respect to an individual, coverage of the individual under any of
23 the following:
- 24 1. A group health plan;
 - 25 2. Health insurance coverage;
 - 26 3. Part A or Part B of Title XVIII of the Social Security Act;
 - 27 4. Title XIX of the Social Security Act, other than coverage consisting

1 solely of benefits under section 1928;

2 5. Chapter 55 of Title 10, United States Code, including medical and dental
3 care for members and certain former members of the uniformed services,
4 and for their dependents; for purposes of Chapter 55 of Title 10, United
5 States Code, "uniformed services" means the Armed Forces and the
6 Commissioned Corps of the National Oceanic and Atmospheric
7 Administration and of the Public Health Service;

8 6. A medical care program of the Indian Health Service or of a tribal
9 organization;

10 7. A state health benefits risk pool;

11 8. A health plan offered under Chapter 89 of Title 5, United States Code,
12 such as the Federal Employees Health Benefit Program;

13 9. A public health plan as established or maintained by a state, the United
14 States government, a foreign country, or any political subdivision of a
15 state, the United States government, or a foreign country that provides
16 health coverage to individuals who are enrolled in the plan;

17 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
18 U.S.C. sec. 2504(e)); or

19 11. Title XXI of the Social Security Act, such as the State Children's Health
20 Insurance Program; and

21 (b) Does not include coverage consisting solely of coverage of excepted benefits
22 as defined in this section;

23 ~~(11)~~⁽⁹⁾ "Dependent" means any individual who is or may become eligible for
24 coverage under the terms of an individual or group health benefit plan because of a
25 relationship to a participant;

26 **(12) "Emergency health care services" means health care services that are provided**
27 **in a health facility after the sudden onset of an emergency medical condition;**

1 (13) "Emergency medical condition" means:

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

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

9 2. Serious impairment to bodily functions; or

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

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

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

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

16 (14)~~(10)~~ "Employee benefit plan" means an employee welfare benefit plan or an
17 employee pension benefit plan or a plan which is both an employee welfare benefit
18 plan and an employee pension benefit plan as defined by ERISA;

19 (15)~~(11)~~ "Eligible individual" means an individual:

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

- 1 (b) Who is not eligible for coverage under a group health plan, Part A or Part B of
2 Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a
3 state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et
4 seq.) and does not have other health insurance coverage;
- 5 (c) With respect to whom the most recent coverage within the coverage period
6 described in paragraph (a) of this subsection was not terminated based on a
7 factor described in KRS 304.17A-240(2)(a), (b), and (c);
- 8 (d) If the individual had been offered the option of continuation coverage under a
9 COBRA continuation provision or under KRS 304.18-110, who elected the
10 coverage; and
- 11 (e) Who, if the individual elected the continuation coverage, has exhausted the
12 continuation coverage under the provision or program;
- 13 (16)~~[(12)]~~ "Employer-organized association" means any of the following:
- 14 (a) Any entity that was qualified by the commissioner as an eligible association
15 prior to April 10, 1998, and that has actively marketed a health insurance
16 program to its members since September 8, 1996, and which is not insurer-
17 controlled;
- 18 (b) Any entity organized under KRS 247.240 to 247.370 that has actively
19 marketed health insurance to its members and that is not insurer-controlled;
- 20 (c) Any entity or association of employers, which has been actively in existence
21 for at least two (2) years, formed under the Employee Retirement Income
22 Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare
23 benefit plan under guidance issued by the United States Department of Labor
24 prior to the issuance of 29 C.F.R. sec. 2510.3-5, and for which the entity's
25 health insurance decisions are made by a board or committee, the majority of
26 which are representatives of employer members of the entity who obtain
27 group health insurance coverage through the entity or through a trust or other

1 mechanism established by the entity, and whose health insurance decisions are
2 reflected in written minutes or other written documentation; and

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

8 Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and
9 except as otherwise provided by the definition of "large group" contained in this
10 section, an employer-organized association shall not be treated as an association,
11 small group, or large group under this subtitle, except that an employer-organized
12 association as defined under paragraph (c) or (d) of this subsection shall be treated
13 as a large group under this subtitle;

14 (17)~~[(13)]~~ "Employer-organized association health insurance plan" means any health
15 insurance plan, policy, or contract issued to an employer-organized association, or
16 to a trust established by one (1) or more employer-organized associations, or
17 providing coverage solely for the employees, retired employees, directors and their
18 spouses and dependents of the members of one (1) or more employer-organized
19 associations;

20 (18)~~[(14)]~~ "Excepted benefits" means benefits under one (1) or more, or any combination
21 of the following:

- 22 (a) Coverage only for accident, including accidental death and dismemberment,
23 or disability income insurance, or any combination thereof;
- 24 (b) Coverage issued as a supplement to liability insurance;
- 25 (c) Liability insurance, including general liability insurance and automobile
26 liability insurance;
- 27 (d) Workers' compensation or similar insurance;

- 1 (e) Automobile medical payment insurance;
- 2 (f) Credit-only insurance;
- 3 (g) Coverage for on-site medical clinics;
- 4 (h) Other similar insurance coverage, specified in administrative regulations,
- 5 under which benefits for medical care are secondary or incidental to other
- 6 insurance benefits;
- 7 (i) Limited scope dental or vision benefits;
- 8 (j) Benefits for long-term care, nursing home care, home health care, community-
- 9 based care, or any combination thereof;
- 10 (k) Such other similar, limited benefits as are specified in administrative
- 11 regulations;
- 12 (l) Coverage only for a specified disease or illness;
- 13 (m) Hospital indemnity or other fixed indemnity insurance;
- 14 (n) Benefits offered as Medicare supplemental health insurance, as defined under
- 15 section 1882(g)(1) of the Social Security Act;
- 16 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
- 17 United States Code;
- 18 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
- 19 supplemental to coverage under a group health plan; and
- 20 (q) Health flexible spending arrangements;
- 21 (19)~~((15))~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
- 22 1002(32);
- 23 (20)~~((16))~~ "Group health plan" means a plan, including a self-insured plan, of or
- 24 contributed to by an employer, including a self-employed person, or employee
- 25 organization, to provide health care directly or otherwise to the employees, former
- 26 employees, the employer, or others associated or formerly associated with the
- 27 employer in a business relationship, or their families;

- 1 ~~(21)~~~~(17)~~ "Guaranteed acceptance program participating insurer" means an insurer that
2 is required to or has agreed to offer health benefit plans in the individual market to
3 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
4 304.17A-480;
- 5 ~~(22)~~~~(18)~~ "Guaranteed acceptance program plan" means a health benefit plan in the
6 individual market issued by an insurer that provides health benefits to a guaranteed
7 acceptance program qualified individual and is eligible for assessment and refunds
8 under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
- 9 ~~(23)~~~~(19)~~ "Guaranteed acceptance program" means the Kentucky Guaranteed
10 Acceptance Program established and operated under KRS 304.17A-400 to
11 304.17A-480;
- 12 ~~(24)~~~~(20)~~ "Guaranteed acceptance program qualified individual" means an individual
13 who, on or before December 31, 2000:
- 14 (a) Is not an eligible individual;
- 15 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
16 spouse or a dependent of an individual who:
- 17 1. Waived coverage under KRS 304.17A-210(2); or
18 2. Did not elect family coverage that was available through the association
19 or group market;
- 20 (c) Within the previous three (3) years has been diagnosed with or treated for a
21 high-cost condition or has had benefits paid under a health benefit plan for a
22 high-cost condition, or is a high risk individual as defined by the underwriting
23 criteria applied by an insurer under the alternative underwriting mechanism
24 established in KRS 304.17A-430(3);
- 25 (d) Has been a resident of Kentucky for at least twelve (12) months immediately
26 preceding the effective date of the policy; and
- 27 (e) Has not had his or her most recent coverage under any health benefit plan

1 terminated or nonrenewed because of any of the following:

- 2 1. The individual failed to pay premiums or contributions in accordance
3 with the terms of the plan or the insurer had not received timely
4 premium payments;
- 5 2. The individual performed an act or practice that constitutes fraud or
6 made an intentional misrepresentation of material fact under the terms of
7 the coverage; or
- 8 3. The individual engaged in intentional and abusive noncompliance with
9 health benefit plan provisions;

10 ~~(25)~~~~[(24)]~~ "Guaranteed acceptance plan supporting insurer" means either an insurer, on
11 or before December 31, 2000, that is not a guaranteed acceptance plan participating
12 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
13 guaranteed acceptance plan supporting insurer shall not include an employer-
14 sponsored self-insured health benefit plan exempted by ERISA;

15 ~~(26)~~~~[(22)]~~ "Health benefit plan":

16 (a) Shall include any:

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

1 delivery in Kentucky; and

2 (b) Does not include:

- 3 1. Policies covering only accident, credit, dental, disability income, fixed
4 indemnity medical expense reimbursement, long-term care, Medicare
5 supplement, specified disease, or vision care;
- 6 2. Coverage issued as a supplement to liability insurance;
- 7 3. Insurance arising out of a workers' compensation or similar law;
- 8 4. Automobile medical-payment insurance;
- 9 5. Insurance under which benefits are payable with or without regard to
10 fault and that is statutorily required to be contained in any liability
11 insurance policy or equivalent self-insurance;
- 12 6. Short-term limited-duration coverage;
- 13 7. Student health insurance offered by a Kentucky-licensed insurer under
14 written contract with a university or college whose students it proposes
15 to insure;
- 16 8. Medical expense reimbursement policies specifically designed to fill
17 gaps in primary coverage, coinsurance, or deductibles and provided
18 under a separate policy, certificate, or contract;
- 19 9. Coverage supplemental to the coverage provided under Chapter 55 of
20 Title 10, United States Code;
- 21 10. Limited health service benefit plans;
- 22 11. Direct primary care agreements established under KRS 311.6201,
23 311.6202, 314.198, and 314.199; or
- 24 12. Coverage provided under KRS Chapter 205;

25 (27)~~[(23)]~~ "Health care provider" or "provider" means any:

- 26 (a) Advanced practice registered nurse licensed under KRS Chapter 314;
- 27 (b) Chiropractor licensed under KRS Chapter 312;

- 1 (c) Dentist licensed under KRS Chapter 313;
- 2 (d) Facility or service required to be licensed under KRS Chapter 216B;
- 3 (e) Home medical equipment and services provider licensed under KRS Chapter
- 4 309;
- 5 (f) Optometrist licensed under KRS Chapter 320;
- 6 (g) Pharmacist licensed under KRS Chapter 315;
- 7 (h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;
- 8 (i) Physician assistant regulated under KRS Chapter 311; and
- 9 (j) Other health care practitioners as determined by the department by
- 10 administrative regulations promulgated under KRS Chapter 13A;
- 11 ~~(28)~~~~(24)~~ (a) "Health care service" means health care procedures, treatments, or
- 12 services rendered by a provider within the scope of practice for which the
- 13 provider is licensed.
- 14 (b) Health care service includes the provision of prescription drugs, as defined in
- 15 KRS 315.010, and home medical equipment, as defined in KRS 309.402;
- 16 ~~(29)~~~~(25)~~ "Health facility" or "facility" has the same meaning as in KRS 216B.015;
- 17 ~~(30)~~~~(26)~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
- 18 Program, means a covered condition in an individual policy as listed in
- 19 paragraph (c) of this subsection or as added by the commissioner in
- 20 accordance with KRS 304.17A-280, but only to the extent that the condition
- 21 exceeds the numerical score or rating established pursuant to uniform
- 22 underwriting standards prescribed by the commissioner under paragraph (b) of
- 23 this subsection that account for the severity of the condition and the cost
- 24 associated with treating that condition.
- 25 (b) The commissioner by administrative regulation shall establish uniform
- 26 underwriting standards and a score or rating above which a condition is
- 27 considered to be high-cost by using:

- 1 1. Codes in the most recent version of the "International Classification of
2 Diseases" that correspond to the medical conditions in paragraph (c) of
3 this subsection and the costs for administering treatment for the
4 conditions represented by those codes; and
 - 5 2. The most recent version of the questionnaire incorporated in a national
6 underwriting guide generally accepted in the insurance industry as
7 designated by the commissioner, the scoring scale for which shall be
8 established by the commissioner.
- 9 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
10 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
11 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
12 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
13 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
14 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,
15 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
16 stroke, syringomyelia, Wilson's disease, and amyotrophic lateral sclerosis;
- 17 (31)~~[(27)]~~ "Index rate" means, for each class of business as to a rating period, the
18 arithmetic average of the applicable base premium rate and the corresponding
19 highest premium rate;
- 20 (32)~~[(28)]~~ "Individual market" means the market for the health insurance coverage
21 offered to individuals other than in connection with a group health plan. The
22 individual market includes an association plan that is not employer-related, issued
23 to individuals on an individually underwritten basis, other than an employer-
24 organized association or a bona fide association;
- 25 (33)~~[(29)]~~ "Insurer" means any insurance company; health maintenance organization;
26 self-insurer, including a governmental plan, church plan, or multiple employer
27 welfare arrangement, not exempt from state regulation by ERISA; provider-

1 sponsored integrated health delivery network; self-insured employer-organized
2 association, or nonprofit hospital, medical-surgical, dental, or health service
3 corporation authorized to transact health insurance business in Kentucky;

4 ~~(34)~~~~(30)~~ "Insurer-controlled" means that the commissioner has found, in an
5 administrative hearing called specifically for that purpose, that an insurer has or had
6 a substantial involvement in the organization or day-to-day operation of the entity
7 for the principal purpose of creating a device, arrangement, or scheme by which the
8 insurer segments employer groups according to their actual or anticipated health
9 status or actual or projected health insurance premiums;

10 ~~(35)~~~~(31)~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001;

11 ~~(36)~~~~(32)~~ "Large group" means:

- 12 (a) An employer with fifty-one (51) or more employees;
13 (b) An affiliated group with fifty-one (51) or more eligible members; or
14 (c) A fully insured employer-organized association as defined in subsection
15 ~~(16)~~~~(12)~~(c) or (d) of this section that:

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

19 ~~(37)~~~~(33)~~ "Managed care" means systems or techniques generally used by third-party
20 payors or their agents to affect access to and control payment for health care
21 services and that integrate the financing and delivery of appropriate health care
22 services to covered persons by arrangements with participating providers who are
23 selected to participate on the basis of explicit standards for furnishing a
24 comprehensive set of health care services and financial incentives for covered
25 persons using the participating providers and procedures provided for in the plan;

26 ~~(38)~~~~(34)~~ "Market segment" means the portion of the market covering one (1) of the
27 following:

- 1 (a) Individual;
- 2 (b) Small group;
- 3 (c) Large group; or
- 4 (d) Association;

5 ~~(39)~~~~[(35)]~~ "Medically necessary health care services" means health care services that a
6 provider would render to a patient for the purpose of preventing, diagnosing, or
7 treating an illness, injury, disease, or its symptoms in a manner that is:

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

10 ~~(40)~~~~[(36)]~~ **"Nonparticipating health care provider" or "nonparticipating provider"**
11 **means a provider that has not entered into an agreement with a covered person's**
12 **insurer to provide health care services to the covered person;**

13 ~~(41)~~ "Participant" means any employee or former employee of an employer, or any
14 member or former member of an employee organization, who is or may become
15 eligible to receive a benefit of any type from an employee benefit plan which covers
16 employees of the employer or members of the organization, or whose beneficiaries
17 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

18 ~~(42)~~~~[(37)]~~ **"Participating health care provider" or "participating provider" means a**
19 **provider that has entered into an agreement with a covered person's insurer to**
20 **provide health care services to the covered person;**

21 ~~(43)~~ "Preventive services" means medical services for the early detection of disease that
22 are associated with substantial reduction in morbidity and mortality;

23 ~~(44)~~~~[(38)]~~ "Provider network" means an affiliated group of varied health care providers
24 that is established to provide a continuum of health care services to individuals;

25 ~~(45)~~~~[(39)]~~ "Provider-sponsored integrated health delivery network" means any provider-
26 sponsored integrated health delivery network created and qualified under KRS
27 304.17A-300 and KRS 304.17A-310;

1 ~~(46)~~~~[(40)]~~ "Purchaser" means an individual, organization, employer, association, or the
2 Commonwealth that makes health benefit purchasing decisions on behalf of a group
3 of individuals;

4 ~~(47)~~~~[(41)]~~ "Rating period" means the calendar period for which premium rates are in
5 effect. A rating period shall not be required to be a calendar year;

6 ~~(48)~~~~[(42)]~~ "Restricted provider network" means a health benefit plan that conditions the
7 payment of benefits, in whole or in part, on the use of the providers that have
8 entered into a contractual arrangement with the insurer to provide health care
9 services to covered persons~~individuals~~;

10 ~~(49)~~~~[(43)]~~ "Self-insured plan" means a group health insurance plan in which the
11 sponsoring organization assumes the financial risk of paying for covered services
12 provided to its enrollees;

13 ~~(50)~~~~[(44)]~~ "Small employer" means, in connection with a group health plan with respect
14 to a calendar year and a plan year, an employer who employed an average of at least
15 two (2) but not more than fifty (50) employees on business days during the
16 preceding calendar year and who employs at least two (2) employees on the first day
17 of the plan year;

18 ~~(51)~~~~[(45)]~~ "Small group" means:

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

21 ~~(52)~~~~[(46)]~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

22 ~~(53)~~~~[(47)]~~ "Telehealth":

- 23 (a) Means the delivery of health care-related services by a health care provider
24 who is licensed in Kentucky to a patient or client through a face-to-face
25 encounter with access to real-time interactive audio and video technology or
26 store and forward services that are provided via asynchronous technologies as
27 the standard practice of care where images are sent to a specialist for

1 evaluation. The requirement for a face-to-face encounter shall be satisfied
2 with the use of asynchronous telecommunications technologies in which the
3 health care provider has access to the patient's or client's medical history prior
4 to the telehealth encounter;

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

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

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

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

13 **(a) Specify a nonprofit organization that maintains a database of billed charges**
14 **submitted by providers for health care services to be used as a benchmark**
15 **for determining the usual and customary rate for health care services under**
16 **Section 3 of this Act. The nonprofit shall not be affiliated with an insurer**
17 **offering health benefit plans in Kentucky; and**

18 **(b) Require all insurers offering health benefit plans in Kentucky to submit to**
19 **the department annually, but no later than March 1 of each year, all of the**
20 **billed charges it receives from both participating and nonparticipating**
21 **providers for each health care service.**

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

23 **(a) Be reported on a form and in a manner determined by the commissioner;**

24 **(b) Not include any personally identifying information of a covered person; and**

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

26 **(3) The department shall provide information reported pursuant to this section to the**
27 **nonprofit identified in subsection (1)(a) of this section. If no nonprofit exists**

1 meeting the requirements of subsection (1)(a) of this section, then the department
2 shall publish this information in a report on its Web site by June 1 of each year.

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

5 (1) As used in this section:

6 (a) "Unanticipated out-of-network care":

7 1. Means covered health care services that are received by the covered
8 person in a health facility from a nonparticipating provider when the
9 covered person did not have the ability to direct that the services be
10 provided by a participating provider, including out-of-network
11 emergency health care services provided to the covered person; and

12 2. Does not include nonemergency health care services, if the covered
13 person voluntarily selects in writing a nonparticipating provider prior
14 to the provision of services;

15 (b) "Covered person" means an individual entitled to receive benefits or
16 services under a health benefit plan; and

17 (c) "Usual and customary rate" means the eightieth percentile of all charges
18 for a particular health care service performed by a health care provider in
19 the same or similar specialty and provided in the same geographical area as
20 reported under Section 2 of this Act.

21 (2) As used in subsection (1) of this section, "covered health care services" means:

22 (a) Health care services that are covered under the covered person's health
23 benefit plan; or

24 (b) Noncovered health care services that would otherwise be covered under the
25 covered person's health benefit plan if the services were provided by a
26 participating provider.

27 (3) A nonparticipating provider shall send a bill for unanticipated out-of-network

1 care to the covered person's insurer. The insurer shall:

2 (a) Reimburse the nonparticipating provider directly, in accordance with
3 subsection (4) of this section; and

4 (b) Send a notice to the nonparticipating provider of any cost-sharing owed
5 under the covered person's health benefit plan for the unanticipated out-of-
6 network care.

7 (4) The reimbursement required by subsection (3) of this section shall be the lower of
8 the following, less any cost-sharing owed under the covered person's health
9 benefit plan for the unanticipated out-of-network care:

10 (a) The billed amount; or

11 (b) The usual and customary rate for each health care service provided.

12 (5) (a) A nonparticipating provider who has been reimbursed under subsection (4)
13 of this section shall not balance bill a covered person.

14 (b) Following the reimbursement from an insurer under subsection (4) of this
15 section, a provider may bill a covered person for any cost-sharing owed
16 under the covered person's health benefit plan for the unanticipated out-of-
17 network care.

18 (6) (a) The coverage required by this section may be subject to cost-sharing, except
19 that an insurer shall limit the cost-sharing required for a covered person's
20 unanticipated out-of-network care to the amount of cost-sharing that would
21 otherwise be owed if the health care services were provided by a
22 participating provider.

23 (b) An insurer shall attribute any cost-sharing owed for unanticipated out-of-
24 network care to any annual deductibles and out-of-pocket maximums
25 included under the terms of the covered person's health benefit plan.

26 ➔Section 4. KRS 18A.225 is amended to read as follows:

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

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

1 sixty-five (65) or older shall not be included, with the exception of
2 persons covered under KRS 61.702(4)(c), unless he or she is actively
3 employed pursuant to subparagraph 1. of this paragraph; and

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

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

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

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

13 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
14 recommendation of the secretary of the Personnel Cabinet, shall procure, in
15 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
16 from one (1) or more insurers authorized to do business in this state, a group
17 health benefit plan that may include but not be limited to health maintenance
18 organization (HMO), preferred provider organization (PPO), point of service
19 (POS), and exclusive provider organization (EPO) benefit plans encompassing
20 all or any class or classes of employees. With the exception of employers
21 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
22 employers of any class of employees or former employees shall enter into a
23 contract with the Personnel Cabinet prior to including that group in the state
24 health insurance group. The contracts shall include but not be limited to
25 designating the entity responsible for filing any federal forms, adoption of
26 policies required for proper plan administration, acceptance of the contractual
27 provisions with health insurance carriers or third-party administrators, and

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

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

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

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

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

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

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

- 1 (g) Any funds in flexible spending accounts that remain after all reimbursements
2 have been processed shall be transferred to the credit of the state-sponsored
3 health insurance plan's appropriation account.
- 4 (h) Each entity participating in the state-sponsored health insurance program shall
5 provide an amount at least equal to the state contribution rate for the employer
6 portion of the health insurance premium. For any participating entity that used
7 the state payroll system, the employer contribution amount shall be equal to
8 but not greater than the state contribution rate.
- 9 (3) The premiums may be paid by the policyholder:
- 10 (a) Wholly from funds contributed by the employee, by payroll deduction or
11 otherwise;
- 12 (b) Wholly from funds contributed by any department, board, agency, public
13 postsecondary education institution, or branch of state, city, urban-county,
14 charter county, county, or consolidated local government; or
- 15 (c) Partly from each, except that any premium due for health care coverage or
16 dental coverage, if any, in excess of the premium amount contributed by any
17 department, board, agency, postsecondary education institution, or branch of
18 state, city, urban-county, charter county, county, or consolidated local
19 government for any other health care coverage shall be paid by the employee.
- 20 (4) If an employee moves his place of residence or employment out of the service area
21 of an insurer offering a managed health care plan, under which he has elected
22 coverage, into either the service area of another managed health care plan or into an
23 area of the Commonwealth not within a managed health care plan service area, the
24 employee shall be given an option, at the time of the move or transfer, to change his
25 or her coverage to another health benefit plan.
- 26 (5) No payment of premium by any department, board, agency, public postsecondary
27 educational institution, or branch of state, city, urban-county, charter county,

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

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

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

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

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

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

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

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

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

26 (13) (a) The policies of health insurance coverage procured under subsection (2) of
27 this section shall include a mail-order drug option for maintenance drugs for

1 state employees. Maintenance drugs may be dispensed by mail order in
2 accordance with Kentucky law.

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

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

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

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

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

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

- 1 (18) If a state employee's residence and place of employment are each located in counties
2 in which the hospitals do not offer surgical services, intensive care services,
3 obstetrical services, level II neonatal services, diagnostic cardiac catheterization
4 services, and magnetic resonance imaging services, the employee may select a plan
5 available in a county contiguous to the county of residence that does provide those
6 services, and the state contribution for the plan shall be the amount available in the
7 county where the plan selected is located.
- 8 (19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and
9 in the best interests of the state group to allow any carrier bidding to offer health
10 care coverage under this section to submit bids that may vary county by county or
11 by larger geographic areas.
- 12 (20) Notwithstanding any other provision of this section, the bid for proposals for health
13 insurance coverage for calendar year 2004 shall include a bid scenario that reflects
14 the statewide rating structure provided in calendar year 2003 and a bid scenario that
15 allows for a regional rating structure that allows carriers to submit bids that may
16 vary by region for a given product offering as described in this subsection:
- 17 (a) The regional rating bid scenario shall not include a request for bid on a
18 statewide option;
- 19 (b) The Personnel Cabinet shall divide the state into geographical regions which
20 shall be the same as the partnership regions designated by the Department for
21 Medicaid Services for purposes of the Kentucky Health Care Partnership
22 Program established pursuant to 907 KAR 1:705;
- 23 (c) The request for proposal shall require a carrier's bid to include every county
24 within the region or regions for which the bid is submitted and include but not
25 be restricted to a preferred provider organization (PPO) option;
- 26 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
27 carrier all of the counties included in its bid within the region. If the Personnel

1 Cabinet deems the bids submitted in accordance with this subsection to be in
2 the best interests of state employees in a region, the cabinet may award the
3 contract for that region to no more than two (2) carriers; and

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

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

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

16 (a) Section 3 of this Act;

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

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

19 (d) KRS 205.593;

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

21 (f) KRS 304.14-135;

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

23 (h) KRS 304.99-123;

24 (i) KRS 304.17A-138; and

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

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

1 after July 12, 2006, to public employees shall comply with KRS 304.17A 600 to
2 304.17A 633 pertaining to utilization review, KRS 205.593 and 304.17A 700 to
3 304.17A 730 pertaining to payment of claims, KRS 304.14 135 pertaining to
4 uniform health insurance claim forms, KRS 304.17A 580 and 304.17A 641
5 pertaining to emergency medical care, KRS 304.99 123, and any administrative
6 regulations promulgated thereunder.

7 (24) Any fully insured health benefit plan or self-insured plan issued or renewed on
8 or after July 1, 2019, to public employees pursuant to this section shall comply with KRS
9 304.17A 138.]

10 ➔Section 5. KRS 304.17A-0954 is amended to read as follows:

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

16 (2) The following restrictions shall be applied in calculating the permissible amount or
17 rate of premiums for an employer-organized association health insurance plan
18 issued to an employer-organized association as defined in KRS 304.17A-
19 005(16)(12)(a) to (c):

20 (a) The premium rates charged during a rating period to members of the
21 employer-organized association with similar characteristics for the same or
22 similar coverage, or the premium rates that could be charged to a member of
23 the employer-organized association under the rating system for that class of
24 business, shall not vary from its own index rate by more than fifty percent
25 (50%) of its own index rate;

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

1 the sum of the following:

2 1. The percentage change in the new business premium rate for the
3 employer-organized association measured from the first day of the prior
4 rating period to the first day of the new rating period;

5 2. Any adjustment, not to exceed twenty percent (20%) annually and
6 adjusted pro rata for rating period of less than one (1) year, due to the
7 claims experience, mental and physical condition, including medical
8 condition, medical history, and health service utilization, or duration of
9 coverage of the member as determined from the insurer's rate manual;
10 and

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

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

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

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

26 ➔Section 6. KRS 304.17A-096 is amended to read as follows:

27 (1) An insurer authorized to engage in the business of insurance in the Commonwealth

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

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

9 (3) An insurer in the individual, small group, or employer-organized association
10 markets that offers a basic health benefit plan may offer a basic health benefit plan
11 that excludes from coverage any state-mandated health insurance benefit, except
12 that the basic health benefit plan shall include coverage for diabetes as provided in
13 KRS 304.17A-148, hospice as provided in KRS 304.17A-250~~[(6)]~~, chiropractic
14 benefits as provided in KRS 304.17A-171, mammograms as provided in KRS
15 304.17A-133, and those mandated benefits specified under federal law.

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

19 ➔Section 7. KRS 304.17A-500 is amended to read as follows:

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

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

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

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

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

- 1 ~~(a) A medical condition manifesting itself by acute symptoms of sufficient severity,~~
2 ~~including severe pain, that a prudent layperson would reasonably have cause to~~
3 ~~believe constitutes a condition that the absence of immediate medical attention~~
4 ~~could reasonably be expected to result in:~~
- 5 1. ~~Placing the health of the individual or, with respect to a pregnant woman, the health~~
6 ~~of the woman or her unborn child, in serious jeopardy;~~
- 7 2. ~~Serious impairment to bodily functions; or~~
- 8 3. ~~Serious dysfunction of any bodily organ or part; or~~
- 9 ~~(b) With respect to a pregnant woman who is having contractions:~~
- 10 1. ~~A situation in which there is inadequate time to effect a safe transfer to another~~
11 ~~hospital before delivery; or~~
- 12 2. ~~A situation in which transfer may pose a threat to the health or safety of the woman~~
13 ~~or the unborn child;~~
- 14 ~~(5)~~ "Enrollee" means a person who is enrolled in a plan offered by a health
15 maintenance organization as defined in KRS 304.38-030(5);
- 16 ~~(5)~~~~(6)~~ "Grievance" means a written complaint submitted by or on behalf of an
17 enrollee;
- 18 ~~(6)~~~~(7)~~ "Health insurance policy" means "health benefit plan" as defined in KRS
19 304.17A-005;
- 20 ~~(7)~~~~(8)~~ "Insurer" ~~has the meaning provided in KRS 304.17A-005;~~
- 21 ~~(9)~~ "Managed care plan" means a health insurance policy that integrates the financing
22 and delivery of appropriate health care services to enrollees by arrangements with
23 participating providers who are selected to participate on the basis of explicit
24 standards to furnish a comprehensive set of health care services and financial
25 incentives for enrollees to use the participating providers and procedures provided
26 for in the plan;
- 27 ~~(8)~~~~(10)~~ "Participating health care provider" ~~means a health care provider that has~~

1 ~~entered into an agreement with an insurer to provide health care services;~~

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

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

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

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

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

26 ➔Section 8. KRS 304.17A-580 (Effective January 1, 2020) is amended to read as
27 follows:

- 1 (1) An insurer offering health benefit plans shall educate its insureds about the
2 availability, location, and appropriate use of emergency and other medical services,
3 cost-sharing provisions for emergency services, and the availability of care outside
4 an emergency department.
- 5 (2) An insurer offering health benefit plans shall cover emergency medical conditions
6 and shall pay for emergency department screening and stabilization services both in-
7 network and out-of-network without prior authorization for conditions that
8 reasonably appear to a prudent layperson to constitute an emergency medical
9 condition based on the patient's presenting symptoms and condition. An insurer
10 shall be prohibited from denying the emergency department services and altering
11 the level of coverage or cost-sharing requirements for any condition or conditions
12 that constitute an emergency medical condition as defined in Section 1 of this
13 Act~~[KRS 304.17A-500]~~.
- 14 (3) Emergency department personnel shall contact a patient's primary care provider or
15 insurer, as appropriate, to discuss follow-up and poststabilization care and promote
16 continuity of care.
- 17 (4) Nothing in this section shall apply to accident-only, specified disease, hospital
18 indemnity, Medicare supplement, long-term care, disability income, or other
19 limited-benefit health insurance policies.
- 20 ➔Section 9. KRS 304.17A-649 is amended to read as follows:
- 21 The commissioner shall promulgate administrative regulations necessary to implement
22 the provisions of KRS ~~{304.17A-640, }304.17A-641, 304.17A-643, 304.17A-645, and~~
23 304.17A-647.
- 24 ➔Section 10. KRS 304.17B-001 is amended to read as follows:
- 25 As used in this subtitle, unless the context requires otherwise:
- 26 (1) "Administrator" is defined in KRS 304.9-051(1);
- 27 (2) "Agent" is defined in KRS 304.9-020;

- 1 (3) "Assessment process" means the process of assessing and allocating guaranteed
2 acceptance program losses or Kentucky Access funding as provided for in KRS
3 304.17B-021;
- 4 (4) "Authority" means the Kentucky Health Care Improvement Authority;
- 5 (5) "Case management" means a process for identifying an enrollee with specific health
6 care needs and interacting with the enrollee and their respective health care
7 providers in order to facilitate the development and implementation of a plan that
8 efficiently uses health care resources to achieve optimum health outcome;
- 9 ~~(6) "Commissioner" is defined in KRS 304.1-050(1);~~
- 10 ~~(7) "Department" is defined in KRS 304.1-050(2);~~
- 11 ~~(8)~~ "Earned premium" means the portion of premium paid by an insured that has been
12 allocated to the insurer's loss experience, expenses, and profit year to date;
- 13 ~~(7)~~~~(9)~~ "Enrollee" means a person who is enrolled in a health benefit plan offered
14 under Kentucky Access;
- 15 ~~(8)~~~~(10)~~ "Eligible individual" is defined in KRS 304.17A-005~~(11)~~;
- 16 ~~(9)~~~~(11)~~ "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed
17 Acceptance Program established and operated under KRS 304.17A-400 to
18 304.17A-480;
- 19 ~~(10)~~~~(12)~~ "Guaranteed acceptance program participating insurer" means an insurer that
20 offered health benefit plans through December 31, 2000, in the individual market to
21 guaranteed acceptance program qualified individuals;
- 22 ~~(11)~~~~(13)~~ "Health benefit plan" is defined in KRS 304.17A-005~~(22)~~;
- 23 ~~(12)~~~~(14)~~ "High-cost condition" means acquired immune deficiency syndrome (AIDS),
24 angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary
25 insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia,
26 Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic
27 cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy,

1 myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic
2 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease,
3 chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the
4 bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short
5 gestation period for a newborn child, and low birth weight of a newborn child;
6 (13)~~[(15)]~~ "Incurred losses" means for Kentucky Access the excess of claims paid over
7 premiums received;
8 (14)~~[(16)]~~ "Insurer" is defined in KRS 304.17A-005~~[(27)]~~;
9 (15)~~[(17)]~~ "Kentucky Access" means the program established in accordance with KRS
10 304.17B-001 to 304.17B-031;
11 (16)~~[(18)]~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;
12 (17)~~[(19)]~~ "Kentucky Health Care Improvement Authority" means the board established
13 to administer the program initiatives listed in KRS 304.17B-003(5);
14 (18)~~[(20)]~~ "Kentucky Health Care Improvement Fund" means the fund established for
15 receipt of the Kentucky tobacco master settlement moneys for program initiatives
16 listed in KRS 304.17B-003(5);
17 (19)~~[(21)]~~ "MARS" means the Management Administrative Reporting System
18 administered by the Commonwealth;
19 (20)~~[(22)]~~ "Medicaid" means coverage in accordance with Title XIX of the Social
20 Security Act, 42 U.S.C. secs. 1396 et seq., as amended;
21 (21)~~[(23)]~~ "Medicare" means coverage under both Parts A and B of Title XVIII of the
22 Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;
23 (22)~~[(24)]~~ "Office" means the Office of Health Data and Analytics in the Cabinet for
24 Health and Family Services;
25 (23)~~[(25)]~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~[(6)]~~;
26 (24)~~[(26)]~~ "Standard health benefit plan" means a health benefit plan that meets the
27 requirements of KRS 304.17A-250;

1 ~~(25)~~~~(27)~~ "Stop-loss carrier" means any person providing stop-loss health insurance
2 coverage;

3 ~~(26)~~~~(28)~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured
4 employer-controlled or bona fide associations; and

5 ~~(26)~~~~(29)~~ "Utilization management" is defined in KRS 304.17A-500~~(12)~~.

6 ➔Section 11. KRS 304.17B-015 is amended to read as follows:

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

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

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

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

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

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

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

26 (a) 1. The individual has, or is eligible for, on the effective date of coverage
27 under Kentucky Access, substantially similar coverage under another

1 contract or policy, unless the individual was issued coverage from a
2 GAP participating insurer as a GAP qualified individual prior to January
3 1, 2001. A GAP qualified individual shall be automatically eligible for
4 coverage under Kentucky Access without regard to the requirements of
5 subsection (2) of this section; or

- 6 2. For eligible individuals as defined in ~~meeting the requirements of~~ KRS
7 304.17A-005~~((11))~~, the individual has, or is eligible for, on the effective
8 date of coverage under Kentucky Access, coverage under a group health
9 plan.

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

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

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

- 21 (d) Except for covered benefits paid under the standard health benefit plan as
22 specified in KRS 304.17B-019, Kentucky Access has paid two million dollars
23 (\$2,000,000) in covered benefits per individual. The maximum limit under
24 this paragraph may be increased by the office;

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

1 (f) The individual's premium, deductible, coinsurance, or copayment is partially
2 or entirely paid or reimbursed by an individual or entity other than the
3 individual or the individual's parent, grandparent, spouse, child, stepchild,
4 father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-
5 law, sister-in-law, grandchild, guardian, or court-appointed payor.

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

9 ➔Section 12. KRS 304.17B-033 is amended to read as follows:

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

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

20 ➔Section 13. KRS 304.17C-010 is amended to read as follows:

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

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

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

25 (3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-
26 005~~[(23)]~~;

27 (4) "Insurer" means any insurance company, health maintenance organization, self-

1 insurer or multiple employer welfare arrangement not exempt from state regulation
2 by ERISA, provider-sponsored integrated health delivery network, self-insured
3 employer-organized association, nonprofit hospital, medical-surgical, dental, health
4 service corporation, or limited health service organization authorized to transact
5 health insurance business in Kentucky who offers a limited health service benefit
6 plan; and

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

13 ➔Section 14. KRS 304.18-114 is amended to read as follows:

14 (1) As used in this section:

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

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

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

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

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

27 (b) The former group member must make written application to the insurer for

1 conversion health insurance coverage not later than thirty-one (31) days after
2 notice pursuant to subsection (5) of this section; and

3 (c) The former group member must pay the monthly, quarterly, semiannual, or
4 annual premium, at the option of the applicant, to the insurer not later than
5 thirty-one (31) days after notice pursuant to subsection (5) of this section.

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

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

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

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

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

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

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

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

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

27 (a) On the effective date of coverage, the applicant is or could be covered by

1 Medicare;

2 (b) On the effective date of coverage, the applicant is or could be covered by
3 another group coverage (insured or uninsured) or, the applicant is covered by
4 substantially similar benefits by another individual hospital, surgical, or
5 medical expenses insurance policy; or

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

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

13 (a) For group policies delivered, issued for delivery, or renewed after July 15,
14 2002, the insurer shall give written notice of the right to conversion health
15 insurance coverage to any former group member entitled to conversion
16 coverage under this section upon notice from the group policyholder that the
17 group member has terminated membership in the group, upon termination of
18 the former group member's continued group health insurance coverage
19 pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-
20 005~~[(7)]~~, or upon termination of the group policy for any reason. The written
21 notice shall clearly explain the former group member's right to a conversion
22 policy.

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

26 (c) If a former group member becomes entitled to obtain conversion health
27 insurance coverage, pursuant to this section, and the insurer fails to give the

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

17 ➔Section 15. KRS 304.38A-010 is amended to read as follows:

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

- 19 (1) "Enrollee" means an individual who is enrolled in a limited health services benefit
20 plan;
- 21 (2) "Evidence of coverage" means any certificate, agreement, contract, or other
22 document issued to an enrollee stating the limited health services to which the
23 enrollee is entitled. All coverages described in an evidence of coverage issued by a
24 limited health service organization are deemed to be "limited health services benefit
25 plans" to the extent defined in KRS 304.17C-010 unless exempted by the
26 commissioner;
- 27 (3) "Limited health service" means dental care services, vision care services, mental

1 health services, substance abuse services, chiropractic services, pharmaceutical
2 services, podiatric care services, and such other services as may be determined by
3 the commissioner to be limited health services. Limited health service shall not
4 include hospital, medical, surgical, or emergency services except as these services
5 are provided incidental to the limited health services set forth in this subsection;

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

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

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

15 ➔Section 16. KRS 304.39-241 is amended to read as follows:

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

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

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

23 (3) Medicaid;

24 (4) Medicare; or

25 (5) A Medicare supplement provider.

26 ➔Section 17. The following KRS section is repealed:

27 304.17A-640 Definitions for KRS 304.17A-640 et seq.

1 ➔Section 18. This Act takes effect January 1, 2021.