AN ACT relating to prior authorization.

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

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

(1) On or before the effective date of this Act, an insurer offering a health benefit plan shall develop a process for electronically requesting and transmitting prior authorization for a drug by providers. The process shall be accessible by providers and meet the most recent National Council for Prescription Drug Programs' SCRIPT standards for electronic prior authorization transactions adopted by the United States Department of Health and Human Services. Facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

(2) Unless otherwise prohibited by state or federal law, if a provider receives a prior authorization for a drug prescribed to a covered person with a condition that requires ongoing medication therapy, and the provider continues to prescribe the drug, and the drug has not been deemed unsafe by the United States Food and Drug Administration, or withdrawn by the manufacturer or the United States Food and Drug Administration, the prior authorization received shall be valid for the lessor of:

(a) One (1) year from the date the provider receives the prior authorization; or

(b) Until the last day of coverage under the covered person's health benefit plan during a single plan year.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

The Department for Medicaid Services shall comply with the provisions of Section 1 and Sections 8, 9, 10, and 11 of this Act.

➔Section 3. KRS 205.522 is amended to read as follows:

All contracts between a managed care organization that provides Medicaid benefits pursuant to this chapter ***and the Department that are entered into or renewed after the effective date of this Act*** shall ***require that the managed care organization*** comply with the provisions of KRS 304.17A-235***,*** ~~[and]~~ 304.17A-740 to 304.17A-743***, Section 1 and Sections 8, 9, 10, and 11 of this Act***.

➔Section 4. KRS 217.211 is amended to read as follows:

(1) Electronic prescribing of a drug or device under this chapter shall not interfere with a patient's freedom to select a pharmacy.

(2) Electronic prescribing software used by a practitioner to prescribe a drug or device under this chapter may include clinical messaging and messages in pop-up windows directed to the practitioner regarding a particular drug or device that supports the practitioner's clinical decision making.

(3) Drug information contained in electronic prescribing software to prescribe a drug or device under this chapter shall be consistent with Food and Drug Administration-approved information regarding a particular drug or device.

(4) ***(a)*** Electronic prescribing software used by a practitioner to prescribe a drug or device under this chapter may show information regarding a payor's formulary, copayments, or benefit plan, provided that nothing in the software is designed to preclude a practitioner from selecting any particular pharmacy or drug or device.

(b) If electronic prescribing software does show information regarding a payor's formulary, payments, or benefit plan under paragraph (a) of this subsection, the information shall be updated at least monthly to ensure its accuracy.

(5) ~~[Within twenty-four (24) months of the National Council for Prescription Drug Programs developing and making available national standards for electronic prior authorization,]~~Each governmental unit of the Commonwealth promulgating

administrative regulations relating to electronic prescribing ***shall include in the regulations*** ~~[shall consider such electronic prescribing and]~~ electronic prior authorization standards ***meeting the requirements of Section 1 of this Act*** in its implementation of health information technology improvements as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

➔Section 5. KRS 218A.171 is amended to read as follows:

(1) Electronic prescribing of a controlled substance under this chapter shall not interfere with a patient's freedom to select a pharmacy.

(2) Electronic prescribing software used by a practitioner to prescribe a controlled substance under this chapter may include clinical messaging and messages in pop-up windows directed to the practitioner regarding a particular controlled substance that supports the practitioner's clinical decision making.

(3) Drug information contained in electronic prescribing software to prescribe a controlled substance under this chapter shall be consistent with Food and Drug Administration-approved information regarding a particular controlled substance.

(4) Electronic prescribing software used by a practitioner to prescribe a controlled substance under this chapter may show information regarding a payor's formulary, copayments, or benefit plan, provided that nothing in the software is designed to preclude a practitioner from selecting any particular pharmacy or controlled substance.

(5) ~~[Within twenty-four (24) months of the National Council for Prescription Drug Programs developing and making available national standards for electronic prior authorization,]~~Each governmental unit of the Commonwealth promulgating administrative regulations relating to electronic prescribing ***shall include in the regulations***~~[shall consider such electronic prescribing and]~~ electronic prior

authorization standards ***meeting the requirements of Section 1 of this Act*** in its implementation of health information technology improvements as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

➔Section 6. KRS 304.17A-005 is amended to read as follows:

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

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

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

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

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

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

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS

Chapter 312;

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

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

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

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(8) ***"Cost sharing" means any expenditure required under a health benefit plan to be paid by or on behalf of an insured with respect to receiving plan benefits, including coinsurance, deductibles, and copayments. "Cost sharing" does not include premiums, balance billing amounts for out-of-network providers, or spending for noncovered services;***

(9) "Covered services" means health care services for which the insured is entitled to receive benefits under the terms of the insured's health benefit plan;

(10) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United

States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

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

7. A state health benefits risk pool;

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

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

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

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

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in~~[subsection (14) of]~~ this section;

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

(12)~~[(10)]~~ ***"Emergency health care services" or "emergency services" means health care services which are provided in an emergency department after the sudden onset of an emergency medical condition. The term includes but is not limited to:***

(a) Screening examinations and treatments that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to determine the presence of and

evaluate emergency medical conditions; and

(b) Any further examinations and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize a covered person with an emergency medical condition;

(13) "Emergency medical condition" means:

(a) A medical condition or mental health condition, as defined in KRS 304.17A-660, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in:

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

2. Serious impairment to bodily functions;

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

4. In the case of a mental health condition, an individual presenting an immediate danger to the life or safety of the individual or others; or

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

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

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

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

(15) ~~[(11)]~~ "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the

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

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

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

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

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

(16) ~~[(12)]~~ "Employer-organized association" means any of the following:

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

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

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-

91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and except as otherwise provided by the definition of "large group" ***as defined in*** ~~[contained in subsection (30) of]~~ this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in ~~[subsection (5) of]~~ this section shall be treated as a large group under this subtitle;

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

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

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

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

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

(q) Health flexible spending arrangements;

(19) ~~[(15)]~~ "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

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

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

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

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

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

(a) Is not an eligible individual;

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

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

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

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

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

(e) Has not had his or her most recent coverage under any health benefit plan

terminated or nonrenewed because of any of the following:

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

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

(26) ~~[(22)]~~ ***(a)*** "Health benefit plan" means any***:***

1. Hospital or medical expense policy or certificate;

2. Nonprofit hospital, medical-surgical, and health service corporation contract or certificate;

3. Provider sponsored integrated health delivery network;

4. ~~[A]~~Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;

5. Health maintenance organization contract; or

6. ~~[Any]~~Health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky***.*** ~~[, and]~~

(b) The term does not include***:***

1. Policies covering only accident, credit, dental, disability income, fixed

indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care**;**~~[,]~~

2. Coverage issued as a supplement to liability insurance**;**~~[,]~~

3. Insurance arising out of a workers' compensation or similar law**;**~~[,]~~

4. Automobile medical-payment insurance**;**~~[,]~~

5. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance**;**~~[,]~~

6. Short-term coverage**;**~~[,]~~

7. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure**;**~~[,]~~

8. Medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract**;**~~[, or]~~

9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code**;**~~[, or]~~

10. Limited health service benefit plans**;**~~[,]~~ or

11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199;

(27)~~[(23)]~~ "Health care provider" or "provider" means any**:**~~[facility or service required to be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS Chapter 315, or home medical equipment and services provider as defined pursuant to KRS 309.402, and any of the following independent practicing practitioners]~~:

(a) ***Advanced practice registered nurse licensed under KRS Chapter 314***~~[Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311]~~;

(b) ***Chiropractor***~~[Chiropractors]~~ licensed under KRS Chapter 312;

(c) ***Dentist***~~[Dentists]~~ licensed under KRS Chapter 313;

(d) ***Facility or service required to be licensed pursuant to KRS Chapter 216B***~~[Optometrists licensed under KRS Chapter 320]~~;

(e) ***Home medical equipment and services provider licensed under KRS Chapter 309***~~[Physician assistants regulated under KRS Chapter 311]~~;

(f) ***Optometrist licensed under KRS Chapter 320;***~~[Advanced practice registered nurses licensed under KRS Chapter 314; and]~~

(g) ***Pharmacist licensed under KRS Chapter 311;***

(h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;

(i) Physician assistant regulated under KRS Chapter 311; and

(j) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(28) (a) "Health care service" means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed in Kentucky.

(b) The term includes the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

(29) "Health facility" or "facility" has the same meaning as in KRS 216B.015;

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

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

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

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

(c) The diagnosed medical conditions are:

1. Acquired immune deficiency syndrome (AIDS)**;**~~[,]~~

2. Angina pectoris**;**~~[,]~~

3. Ascites**;**~~[,]~~

4. Chemical dependency**;**

5. Cirrhosis of the liver**;**~~[,]~~

6. Coronary insufficiency**;**~~[,]~~

7. Coronary occlusion**;**~~[,]~~

8. Cystic fibrosis**;**~~[,]~~

9. Friedreich's ataxia**;**~~[,]~~

10. Hemophilia**;**~~[,]~~

11. Hodgkin's disease**;**~~[,]~~

12. Huntington chorea**;**~~[,]~~

13. Juvenile diabetes**;**~~[,]~~

14. Leukemia**;**~~[,]~~

15. Metastatic cancer**;**~~[,]~~

16. Motor or sensory aphasia***;*** ~~[,]~~

17. Multiple sclerosis***;*** ~~[,]~~

18. Muscular dystrophy***;*** ~~[,]~~

19. Myasthenia gravis***;*** ~~[,]~~

20. Myotonia***;*** ~~[,]~~

21. Open heart surgery***;*** ~~[,]~~

22. Parkinson's disease***;*** ~~[,]~~

23. Polycystic kidney***;*** ~~[,]~~

24. Psychotic disorders***;*** ~~[,]~~

25. Quadriplegia***;*** ~~[,]~~

26. Stroke***;*** ~~[,]~~

27. Syringomyelia***;*** ~~[,]~~ and

28. Wilson's disease;

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

(32) ~~[(26)]~~ "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association, that has been organized and is maintained in good faith for purposes other than obtaining insurance for its members and that has a constitution and bylaws;

(33) "Insured" or "covered person" means an individual entitled to receive benefits or services under a health benefit plan;

(34) ~~[(27)]~~ "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state

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

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

(36) ~~[(29)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001~~[(17)]~~;

(37) ~~[(30)]~~ "Large group" means:

(a) An employer with fifty-one (51) or more employees;

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) An employer-organized association that is a bona fide association as defined in~~[subsection (5) of]~~ this section;

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

(39) ~~[(32)]~~ "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(40) "Medically necessary health care services" means health care services that a prudent provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(a) In accordance with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, and duration; and

(c) In no part for the economic benefit of the insurer or private review agent, as defined in Section 9 of this Act or for the convenience of the covered person or provider.

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

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

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

(44) ~~[(34)]~~ "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

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

(46) ~~[(36)]~~ "Provider-sponsored integrated health delivery network" means any provider-

sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

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

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

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

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

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

(52) ~~[(42)]~~ "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members;

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

(54) ~~[(44)]~~ "Telehealth" has the meaning provided in KRS 311.550.

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

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

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

definition of urban area;

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

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

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

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

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

~~2. Serious impairment to bodily functions; or~~

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

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

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

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

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

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

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

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

~~(9) ~~"Managed care plan" means a health insurance policy that integrates the financing

and delivery of appropriate health care services to enrollees by arrangements with participating providers who are selected to participate on the basis of explicit standards to furnish a comprehensive set of health care services and financial incentives for enrollees to use the participating providers and procedures provided for in the plan;

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

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

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

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

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

(11) ~~[(15)]~~ "Utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person

should or will be reimbursed, covered, paid for, or otherwise provided under the plan. The system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures, and retrospective review.

➔Section 8. KRS 304.17A-580 is amended to read as follows:

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

(2) An insurer offering health benefit plans shall cover emergency medical conditions and shall pay for ***prehospital emergency medical transportation and*** emergency department screening and stabilization services both in-network and out-of-network without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based on the patient's presenting symptoms and condition. ***For all screening and stabilization services provided to an insured by an emergency department or prehospital emergency medical transportation,*** an insurer shall be prohibited from**:** ~~[ ]~~

(a) Denying the emergency ***department*** ~~[room]~~ services**;** ~~[and]~~

(b) Altering the level of coverage or cost-sharing requirements**;**

(c) Applying any restrictions on coverage for services provided by a nonparticipating provider that are greater than any that apply to services provided by an participating provider; or

(d) Requiring a concurrent or retrospective review, as defined in Section 9 of this Act ~~[for any condition or conditions that constitute an emergency medical condition as defined in KRS 304.17A-500]~~.

(3) ***Screening and stabilization services required to be covered by subsection (2) of this section, shall be deemed to be medically necessary.***

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

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

(6) When a covered person with an emergency medical condition has been stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 42 U.S.C. sec. 1395dd, in an emergency department, and an insurer under its health benefit plan requires prior authorization for poststabilization services, approval or denial under the preauthorization requirement shall be provided within sixty (60) minutes after receiving a preauthorization request, for poststabilization services.

(7) An insurer's failure to make a preauthorization determination within the required time frame under subsection (6) of this section shall be deemed an authorization for poststabilization services for which prior authorization was sought.

(8) Emergency health care services, poststabilization services, or both, provided by a nonparticipating provider shall be paid at a rate negotiated between the nonparticipating provider and the insurer. Nothing in this section is to be construed as requiring the payment of one hundred percent (100%) of the billed charges.

➔Section 9. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" means the document evidencing and setting forth the terms and conditions of coverage of any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network policy or certificate; a self-insured policy or certificate or a policy or certificate provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease,

vision care, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or limited health service benefit plans; and for purposes of KRS 304.17A-600 to 304.17A-633 includes short-term coverage policies;

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) "Nationally recognized accreditation organization" means a private nonprofit entity

that sets national utilization review and internal appeal standards and conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification. Nationally recognized accreditation organizations shall include the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission, or any other organization identified by the department;

(11) "Private review agent" or "agent" means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth. "Private review agent" or "agent" does not include an independent review entity which performs external review of adverse determinations;

(12) "Prospective review" means ***a*** utilization review that is conducted prior to ***the provision of health care services.*** ~~[a hospital admission or a course of treatment]~~ ***"Prospective review" also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy, preadmission review, pretreatment review, utilization, and case management***;

(13) ~~["Provider" shall have the same meaning as set forth in KRS 304.17A-005;~~

~~(14) ~~]"Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;

(14) ~~[(15)]~~ "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review;

(15) ~~[(16)]~~ "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person. "Retrospective review" does

not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(16) ~~[(17)]~~ (a) "Urgent ***health*** care ***services***" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

(b) " Urgent ***health*** care ***services*** " shall include all requests for hospitalization and outpatient surgery;

(17) ~~[(18)]~~ "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. ~~[Areas of review include concurrent, prospective, and retrospective review]~~; and

(18) ~~[(19)]~~ "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

➔Section 10. KRS 304.17A-603 is amended to read as follows:

(1) KRS 304.17A-600 to 304.17A-633 shall apply to any insurer that covers citizens of the Commonwealth under a health benefit plan.

(2) An insurer shall maintain written procedures for:

(a) ~~[(1)]~~ Determining whether a requested service, treatment, drug, or device is covered under the terms of a covered person's health benefit plan;

(b) ~~[(2)]~~ Making utilization review determinations; and

(c) ~~[(3)]~~ Notifying covered persons, authorized persons, and providers acting on

behalf of covered persons of its determinations.

(3) (a) An insurer shall make the written procedures required by this section readily accessible on its Web site to covered persons, authorized persons, and providers.

(b) No written procedures, including any changes to existing procedures, required by this section may be enforced by an insurer under a health benefit plan until the insurer's Web site has been updated to reflect those procedures.

➔Section 11. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that***, for any contract entered into on or after the effective date of this Act for the provision of utilization review services,*** only ~~[licensed]~~physicians ***licensed in Kentucky, who are of the same specialty and subspecialty, when possible, as the ordering provider*** shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, ***or as otherwise provided in this section,*** provide a utilization review decision ~~[relating to urgent and nonurgent care]~~in accordance with ***the timeframes in paragraph (i) of this section and*** 29 C.F.R. Part 2560, including ~~[the timeframes and]~~ written notice of the decision~~[. A written notice in electronic format, including e-mail or facsimile,~~

~~may suffice for this purpose where the covered person, authorized person, or provider has agreed in advance in writing to receive such notices electronically and shall include the required elements of subsection (j) of this section~~];

(i) ***1. For purposes of this paragraph, "necessary information" is limited to:***

a. The results of any face-to-face clinical evaluation;

b. Any second opinion that may be required; and

c. Any other information determined by the department to be necessary to making a utilization review determination.

2. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after receiving all information needed to complete the review of the requested health care services;

3. If an insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within forty-eight (48) hours of obtaining all necessary information to make the utilization review decision; and.

4. If a utilization review is related to the dispensing of a prescription drug, issue an electronic authorization to the covered person's pharmacy for the dispensing of a temporary supply of the prescription drug in sufficient quantity for treatment of the covered person for the period of time until he or she has been notified of the utilization review decision as required under this paragraph. The covered person shall be billed at the in-network cost sharing rate for any temporary supply of a prescription drug required to be dispensed under this

paragraph~~[Provide a utilization review decision within twenty-four (24) hours of receipt of a request for review of a covered person's continued hospital stay and prior to the time when a previous authorization for hospital care will expire]~~;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. ***The written notice may be provided in an electronic format, including e-mail or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically.*** An insurer or agent that denies ***step therapy, as defined in KRS 304.17A-163, overrides or denies*** coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;
2. The ~~[state of licensure,]~~medical license number, and the title of the reviewer making the decision;
3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and
4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the

insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's ***or private review agent's*** failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be ***preauthorization for the health care services or benefits subject to the review*** ~~[an adverse determination by the insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617]~~. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

➔Section 12. KRS 18A.225 is amended to read as follows:

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

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local

government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567;

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

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

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

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

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

(c) The term "insurer" for the purposes of this section means an insurer as defined

in KRS 304.17A-005; and

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

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

coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

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

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

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

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements,

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

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

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

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

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

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

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

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

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

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

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

insurance or coverage after retirement.

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

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

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

(10) Notwithstanding any other provision of law to the contrary, the policy or policies

provided to employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the purpose of obtaining or performing an abortion on behalf of employees or their dependents.

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

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

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

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

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

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

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

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

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

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

(19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and in the best interests of the state group to allow any carrier bidding to offer health

care coverage under this section to submit bids that may vary county by county or by larger geographic areas.

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

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

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

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

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

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

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed

under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

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

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

➔Section 13. KRS 304.17A-096 is amended to read as follows:

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

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

(3) An insurer in the individual, small group, or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health benefit plan shall include coverage for diabetes as provided in

KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic benefits as provided in KRS 304.17A-171, mammograms as provided in KRS 304.17A-133, and those mandated benefits specified under federal law.

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

➔Section 14. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state

employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high-risk individuals rather than using the criteria established in KRS 304.17A-005~~[(24)]~~ and 304.17A-280 for high-cost conditions.

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the

commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

➔Section 15. KRS 304.17B-001 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(10)~~[(12)]~~ "Guaranteed acceptance program participating insurer" means an insurer that offered health benefit plans through December 31, 2000, in the individual market to

guaranteed acceptance program qualified individuals;

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

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

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

(14) ~~[(16)]~~ "Insurer" is defined in KRS 304.17A-005~~[(27)]~~;

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

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

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

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

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

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

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

(22) ~~[(24)]~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~[(6)]~~;

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

(24) ~~[(26)]~~ "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

(25) ~~[(27)]~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured employer-controlled or bona fide associations; and

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

➔Section 16. KRS 304.17B-015 is amended to read as follows:

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

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

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

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

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

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3)

year period and may be used by the enrollee to obtain insurance in the regular individual market.

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

(a) 1. The individual has, or is eligible for, on the effective date of coverage under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section; or

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

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

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

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

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under

this paragraph may be increased by the department;

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

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

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

➔Section 17. KRS 304.17B-033 is amended to read as follows:

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

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

➔Section 18. KRS 304.17C-010 is amended to read as follows:

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

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

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

plan;

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

(4) "Insurer" means any insurance company, health maintenance organization, self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA, provider-sponsored integrated health delivery network, self-insured employer-organized association, nonprofit hospital, medical-surgical, dental, health service corporation, or limited health service organization authorized to transact health insurance business in Kentucky who offers a limited health service benefit plan; and

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

➔Section 19. KRS 304.18-114 is amended to read as follows:

(1) As used in this section:

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

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

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

(2) An insurer providing group health insurance coverage shall offer a conversion health insurance policy, by written notice, to any group member terminated under the group policy for any reason. The insurer shall offer a conversion health insurance policy substantially similar to the group policy. The former group

member shall meet the following conditions:

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

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

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

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

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

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

1. The effective date of the conversion policy; or

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

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

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

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

promulgated thereunder.

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

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

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

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

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

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

(b) The thirty-one (31) day period of subsection (2)(b) of this section shall not

begin to run until the notice required by this subsection is mailed or delivered to the last known address of the former group member.

(c) If a former group member becomes entitled to obtain conversion health insurance coverage, pursuant to this section, and the insurer fails to give the former group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of conversion rights to the former group member and such former group member shall have an additional period within which to exercise his conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the former group member shall constitute the giving of notice for the purpose of this paragraph. If a former group member makes application and pays the premium, for conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage. However, nothing in this subsection shall require an insurer to give notice or provide conversion coverage to a former group member ninety (90) days after termination of the former group member's group coverage.

➔Section 20. KRS 304.38A-010 is amended to read as follows:

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

(1) "Enrollee" means an individual who is enrolled in a limited health services benefit plan;

(2) "Evidence of coverage" means any certificate, agreement, contract, or other document issued to an enrollee stating the limited health services to which the enrollee is entitled. All coverages described in an evidence of coverage issued by a

limited health service organization are deemed to be "limited health services benefit plans" to the extent defined in KRS 304.17C-010 unless exempted by the commissioner;

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

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

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

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

➔Section 21. KRS 304.39-241 is amended to read as follows:

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

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

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

(3) Medicaid;

(4) Medicare; or

(5) A Medicare supplement provider.

➔Section 22. KRS 304.17A-623 is amended to read as follows:

(1) Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g). An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in KRS 304.17A-607~~[(1)(j)]~~ and in the denial letter required in KRS 304.17A-617(1) and (2)(e). For purposes of this section "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) The insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least

one hundred dollars ($100) if the covered person had no insurance.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and

2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days from the receipt of all information required from the insurer. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

➔Section 23. KRS 304.17A-649 is amended to read as follows:

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

➔Section 24. KRS 304.17A-700 is amended to read as follows:

As used in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123:

(1) "Adjudicate" means an insurer pays, contests, or denies a clean claim;

(2) "Claims payment time frame" means the time period prescribed under KRS 304.17A-702 following receipt of a clean claim from a provider at the address published by the insurer, whether it is the address of the insurer or a delegated claims processor, within which an insurer is required to pay, contest, or deny a health care claim;

(3) "Clean claim" means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the following

applicable form:

(a) A clean claim from an institutional provider shall consist of:

1. The UB-92 data set or its successor submitted on the designated paper or electronic format as adopted by the NUBC;
2. Entries stated as mandatory by the NUBC; and
3. Any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service.

(b) A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

(c) A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

(d) A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs;

(4) "Commissioner" means the commissioner of the Department of Insurance;

(5) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services;

(6) "Department" means the Department of Insurance;

(7) "Electronic" or "electronically" means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(8) "Health benefit plan" has the same meaning as provided in KRS 304.17A-005;

(9) "Health care provider" or "provider" means a provider licensed in Kentucky as defined in KRS 304.17A-005 and, for the purposes of KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 only, shall include physical therapists licensed under KRS Chapter 327, psychologists licensed under

KRS Chapter 319, and social workers licensed under KRS Chapter 335. Nothing contained in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123 shall be construed to include physical therapists, psychologists, and social workers as a health care provider or provider under KRS 304.17A-005;

(10) "Health claim attachments" means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to KRS 304.17A-720;

(11) "Institutional provider" means a health care facility licensed under KRS Chapter 216B;

(12) "Insurer" has the same meaning provided in KRS 304.17A-005;

(13) "Kentucky Uniform Billing Committee (KUBC)" means the committee of health care providers, governmental payors, and commercial insurers established as a local arm of NUBC to implement the bill requirements of the NUBC and to prescribe any additional billing requirements unique to Kentucky insurers;

(14) "National Uniform Billing Committee (NUBC)" means the national committee of health care providers, governmental payors, and commercial insurers that develops the national uniform billing requirements for institutional providers as referenced in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Chapter 6A, Subchapter XXV, secs. 300gg et seq.;

(15) "Retrospective review" means utilization review that is conducted after health care services have been provided to a covered person; and

(16) "Utilization review" has the same meaning as provided in KRS 304.17A-600~~[(18)]~~.

➔Section 25. The following KRS sections are repealed:

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

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