AN ACT relating to medical coverage.

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

➔Section 1. KRS 304.17A-578 is repealed, reenacted as a new section of Subtitle 17A of KRS Chapter 304, and amended to read as follows:

(1) As used in this section, unless the context requires otherwise:

(a) "Material change" means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense***, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products***; and

(b) "Participating provider" means a ***provider***~~[physician licensed under KRS Chapter 311, an advanced practice registered nurse licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320]~~ that has entered into an agreement with an insurer to provide health care services.

(2) ***Each insurer offering a health benefit plan shall establish a policy governing the procedures for changing an existing agreement with a participating provider that shall include but not be limited to the requirements of this section.***

(3) If an insurer offering a health benefit plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, the insurer shall:

(a) Provide the participating provider with at least ninety (90) days' notice of the material change. The notice of a material change required under this section shall provide the proposed effective date of the change, and shall include a description of the material change and a statement that the

participating provider has the option to either accept or reject the proposed material change. Acceptance of the material change on the part of the provider may only be evidenced by a written signature. If the participating provider does not respond to the notice of a proposed material change, then the change shall not take effect until a modified arrangement is successfully negotiated or the contractual relationship is ended pursuant to any termination procedures set forth in the original provider agreement;

(b) 1. If the material change relates to the proposed inclusion of the provider in new or modified insurance products, or proposes membership changes to networks, send notice of the proposed material change by certified mail, return receipt requested; or

2. For any other material change, send the notice of proposed material change in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer;

(c) Provide the name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the material change, if requested by the participating provider; and

(d) Provide the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the participating provider. For the purposes of this paragraph, "real-time communication" means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing~~[If an~~

~~insurer issuing a managed care plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, the insurer shall provide the participating provider with at least ninety (90) days' written notice of the material change. The notice shall include a description of the material change and a statement that the participating provider has the option to withdraw from the agreement prior to the material change becoming effective pursuant to subsection (3) of this section~~].

(4)[~~(3)~~] A participating provider who opts to withdraw following notice of a material change pursuant to subsection ***(3)***[~~(2)~~] of this section shall send written notice of withdrawal to the insurer no later than forty-five (45) days prior to the effective date of the material change.

(5)[~~(4)~~] If an insurer issuing a ***health benefit***[~~managed care~~] plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change.

(6) In the event that three (3) or more material changes are made to an existing agreement, the insurer shall issue a new agreement which shall become effective only upon the agreement of both the insurer and the participating provider.

(7) Any notice required to be mailed pursuant to this section shall be sent to the participating provider's point of contact, as set forth in the provider agreement. If no point of contact is set forth in the provider agreement, the insurer shall send the requisite notice to the provider's place of business addressed to the provider.

(8) The provisions of this section apply to any new or renewed provider agreements signed after July 1, 2016.

➔Section 2. KRS 205.522 is amended to read as follows:

A managed care organization that provides Medicaid benefits pursuant to this chapter shall comply with the provisions of ***Section 1 of this Act and*** KRS 304.17A-740 to 304.17A-743.

➔Section 3. KRS 304.17C-060 is amended to read as follows:

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

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

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

2. Insolvency of the insurer; or

3. Breach of the agreement,

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

(b) A survivorship clause that states the hold harmless clause and continuity of care clause shall survive the termination of the agreement between the provider and the insurer;~~[and]~~

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

in accordance with this subsection***; and***

(d) Procedures for changing an existing agreement with a participating provider as defined in Section 1 of this Act, which comply with Section 1 of this Act.

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

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

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

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

(d) Any administrative functions delegated by the insurer to the entity or provider. The insurer shall describe a plan to ensure that the entity or provider will comply with the requirements of this subtitle in exercising any delegated administrative functions; and

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

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

➔Section 4. This Act takes effect January 1, 2017.