AN ACT relating to out-of-network billing.

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

➔Section 1. 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":***

***(a) Means any expenditure required under a health insurance policy or plan, including a health benefit plan, to be paid by, or on behalf of, an insured with respect to receiving benefits under the policy or plan;***

***(b) Shall include coinsurance, copayments, and deductibles; and***

***(c) Shall not include premiums, balance billing amounts for nonparticipating providers, or spending for noncovered services;***

***(9)*** ~~[(8)]~~ "Creditable coverage":

(a) 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; and

(b) ***Shall***~~[Does]~~ not include coverage consisting solely of coverage of excepted benefits as defined in this section;

***(10)***~~[(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;

***(11) "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 in which 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 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;***

***(12)*** ~~[(10)]~~ "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;

***(13)*** ~~[(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;

***(14)*** ~~[(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;

(c) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare benefit plan under guidance issued by the United States Department of Labor prior to the issuance of 29 C.F.R. sec. 2510.3-5, 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; and

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

Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and

except as otherwise provided by the definition of "large group" contained in this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, except that an employer-organized association as defined under paragraph (c) or (d) of this subsection shall be treated as a large group under this subtitle;

***(15)*** ~~[(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;

***(16)*** ~~[(14)]~~ "Excepted benefits" means benefits under one (1) or more, or any combination 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;

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

***(18)*** ~~[(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;

***(19)*** ~~[(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;

***(20)*** ~~[(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;

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

***(22)*** ~~[(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;

***(23)*** ~~[(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;

***(24)*** ~~[(22)]~~ "Health benefit plan":

(a) Shall include 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. Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;
5. Self-insured governmental plan or church plan;
6. Health maintenance organization contract, except contracts to provide Medicaid benefits under KRS Chapter 205; or
7. 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) ***Shall*** ~~[Does]~~ not include:

1. Policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement, long-term care, Medicare supplement, specified disease, or 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 limited-duration 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;
9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;
10. Limited health service benefit plans;
11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199; or
12. Coverage provided under KRS Chapter 205;

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

(a) Advanced practice registered nurse licensed under KRS Chapter 314;
(b) Chiropractor licensed under KRS Chapter 312;
(c) Dentist licensed under KRS Chapter 313;
(d) Facility or service required to be licensed under KRS Chapter 216B;
(e) Home medical equipment and services provider licensed under KRS Chapter 309;
(f) Optometrist licensed under KRS Chapter 320;
(g) Pharmacist licensed under KRS Chapter 315;
(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;

***(26)***~~[(24) (a)]~~ "Health care service"***:***

***(a)*** Means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed***; and***~~[.]~~

(b) ***Shall include***~~[Health care service includes]~~ the provision of***:***

***1.*** Prescription drugs, as defined in KRS 315.010***;***~~[,]~~ and

***2.*** Home medical equipment, as defined in KRS 309.402;

***(27)***~~[(25)]~~ "Health facility" or "facility" has the same meaning as in KRS 216B.015;

***(28)***~~[(26)]~~ (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: 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 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, and amyotrophic lateral sclerosis;

***(29)*** ~~[(27)]~~ "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;

***(30)*** ~~[(28)]~~ "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;

***(31)*** ~~[(29)]~~ "Insurer" means any insurance company; health maintenance organization; self-insurer, including a governmental plan, church plan, 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;

***(32)*** ~~[(30)]~~ "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;

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

***(34)*** ~~[(32)]~~ "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) A fully insured employer-organized association as defined in subsection ***(14)*** ~~[(12)]~~(c) or (d) of this section that:

1. Covers at least fifty-one (51) employee members; and

2. Is registered with the department pursuant to administrative regulations promulgated by the commissioner;

***(35)*** ~~[(33)]~~ "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;

***(36)*** ~~[(34)]~~ "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;

***(37)*** ~~[(35)]~~ "Medically necessary health care services" means health care services that a 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; and

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

***(38) "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;***

***(39)*** ~~[(36)]~~ "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;

***(40) "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;***

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

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

***(43)*** ~~[(39)]~~ "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;

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

***(45)*** ~~[(41)]~~ "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;

***(46)*** ~~[(42)]~~ "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;

***(47)*** ~~[(43)]~~ "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;

***(48)*** ~~[(44)]~~ "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;

***(49)*** ~~[(45)]~~ "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;

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

***(51)*** ~~[(47)]~~ "Telehealth":

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

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

(c) Shall be delivered over a secure communications connection that complies

with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9.

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

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

***(a) Specify a nonprofit organization that maintains a database of billed charges submitted by providers for health care services to be used as a benchmark for determining the usual and customary rate under Section 4 of this Act. The nonprofit shall not be affiliated with an insurer offering health benefit plans in Kentucky; and***

***(b) Require all insurers to submit to the department no later than March 1 of each year, all billed charges received from both participating and nonparticipating providers for each health care service.***

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

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

***(b) Not include any personally identifying information of an insured; and***

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

***(3) The department shall provide information reported pursuant to this section to the nonprofit identified in subsection (1) of this section, which shall make the information available in the database by June 1 of each year, except, if no nonprofit exists meeting the requirements of subsection (1) of this section then the department shall publish this information in a report on its Web site by June 1 of each year.***

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

***(1) As used in this section:***

***(a) "Balance bill" or "balance billing" refers to a provider billing an insured***

***for the remaining balance of the amount a provider charges for a service less the following:***

***1. The amount an insurer reimburses; and***

***2. Any applicable cost sharing the insured is required to pay;***

***(b) "Covered health care services" means:***

***1. Health care services that are covered under an insured's health benefit plan; or***

***2. Noncovered health care services that would otherwise be covered under the insured's health benefit plan if the services were provided by a participating provider;***

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

***(d) "Insured" means a person covered under a health benefit plan;***

***(e) "Median in-network rate" means the median of all contracted commercial rates paid by the health benefit plan, or its delegated entity, for the same or similar health care services in the same geographic region; and***

***(f) "Unanticipated out-of-network care":***

***1. Means covered health care services received by an insured in a health facility from a nonparticipating provider when the insured did not have the ability to direct that the services be provided by a participating provider;***

***2. Shall include out-of-network emergency health care services; and***

***3. Shall not include nonemergency health care services, if the insured voluntarily selects in writing a nonparticipating provider prior to the provision of services.***

***(2) A nonparticipating provider shall send a bill for unanticipated out-of-network***

***care to the insured's insurer. Within the timeframes required under KRS 304.17A-700 to 304.17A-730, the insurer shall:***

***(a) Reimburse the nonparticipating provider at the greater of the following, less any cost sharing owed by the insured:***

***1. The insurer's median in-network rate for the current year; or***

***2. The insurer's median in-network rate for the year 2019; and***

***(b) Send a notice to the nonparticipating provider of any cost sharing owed for the unanticipated out-of-network care. The amount of cost sharing owed shall:***

***1. Not exceed the amount of cost sharing that would have been owed if the services were provided by a participating provider; and***

***2. Be calculated based on the reimbursement amount determined under this section.***

***(3) (a) For purposes of subsection (2)(a) of this section, if the insurer has insufficient information in any year, as specified by the commissioner in accordance with paragraph (b) of this subsection, to calculate the median in-network rate for a health care service furnished in a geographic region by a type of provider, the median in-network rate shall be the median in-network rate recognized by all health plans offered in the same line of business for the health care service furnished in a geographic region using a database or other source information determined appropriate by the commissioner.***

***(b) The commissioner shall promulgate administrative regulations to determine when an insurer has insufficient information to calculate a median in-network rate, which shall include but not be limited to a finding that the insurer's provider network fails to include, as participating providers, the majority of providers located in the geographic region which are of the***

***same provider type as the provider which provided the health care service.***

***(4) A nonparticipating provider who has been reimbursed by an insurer under subsection (2) of this section:***

***(a) Shall not balance bill an insured; and***

***(b) May bill an insured for any applicable cost sharing.***

***(5) (a) Any cost sharing that the insured pays under this section shall be attributable to any annual deductibles and out-of-pocket maximums required under the terms of the insured's health benefit plan.***

***(b) The entire amount paid by the insured to the nonparticipating provider shall be attributable to any annual deductible and out-of-pocket maximums required under the terms of the insured's health benefit plan when an insurer does not make a reimbursement under this section because the cost sharing owed for the unanticipated out-of-network care is equal to or greater than the reimbursement amount determined under this section.***

***(6) Except as provided in Section 4 of this Act, a nonparticipating provider shall accept the reimbursement made under subsection (2) of this section, plus any applicable cost sharing owed by an insured, as the full and final payment for the unanticipated out-of-network care.***

***(7) An appropriate regulatory agency or board that licenses, certifies, or otherwise authorizes a provider to provide health care services in this state may take any disciplinary action that the board or agency is authorized to take against regulated providers under the agency's or board's authorizing statutes against a provider that violates this section.***

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

***(1) As used in this section:***

***(a) "Unanticipated out-of-network care" has the same meaning as in Section 3***

***of this Act; and***

***(b) "Usual and customary rate" means the eightieth percentile of all charges for a particular health care service, as reported under Section 2 of this Act, performed by a health care provider in the same or similar specialty and provided in the same geographic region.***

***(2) The commissioner shall:***

***(a) Establish and administer:***

***1. An independent dispute resolution program in accordance with this section; and***

***2. An application process for qualifying reviewers for the independent dispute resolution program. To be eligible as a qualified reviewer, an individual shall:***

***a. Demonstrate knowledge of and experience in applicable principles of contract and insurance law and the healthcare industry generally; and***

***b. Not have a conflict of interest that would adversely impact the individual's independence or impartiality, including but not limited to current or recent ownership or employment of the individual, or a close family member, in any insurer issuing health benefit plans, administrator of health benefit plans, or health care provider; and***

***(b) Maintain:***

***1. A portal on the department's Web site through which a nonparticipating provider may request to dispute the reimbursement made to that provider under Section 3 of this Act;***

***2. A list of qualified reviewers for the independent dispute resolution program; and***

***3. Records of the information reported under subsection (11) of this section.***

***(3) (a) A nonparticipating provider may elect to dispute the reimbursement made to that provider under Section 3 of this Act if, within thirty (30) days of the reimbursement, the nonparticipating provider submits a dispute request through the portal on the department's Web site.***

***(b) A nonparticipating provider may submit up to ten (10) charges in one (1) dispute request when:***

***1. The reimbursements for the charges are received by the nonparticipating provider within the same thirty (30) day period; and***

***2. The charges are for a similar health care service.***

***(4) If a nonparticipating provider submits a dispute request in accordance with subsection (3) of this section:***

***(a) Both the nonparticipating provider and the insurer shall participate in and comply with the requirements of this section; and***

***(b) On the date the dispute request is submitted, the nonparticipating provider shall provide written notice, which shall include transmissions via e-mail or facsimile, of the request, in a form and manner prescribed by the commissioner, to:***

***1. The commissioner; and***

***2. The insurer.***

***(5) (a) If the cumulative amount of charges for the unanticipated out-of-network care in a dispute request is less than six hundred seventy-five dollars ($675), the parties shall engage in an informal settlement conference in accordance with subsection (6) of this section.***

***(b) 1. If the cumulative amount of charges for the unanticipated out-of-network care in a dispute request is six hundred seventy-five dollars***

***($675) or more, the parties shall engage in an informal settlement conference in accordance with subsection (6) of this section. If a settlement is not reached, the parties shall submit information to a reviewer in accordance with subsection (8)(a) of this section.***

***2. The parties may select a reviewer by agreement. If a selection is made under this paragraph, the nonparticipating provider shall notify the commissioner of the selection within twenty (20) days of the dispute request submitted under subsection (3) of this section.***

***3. If the commissioner has not received notification that the parties have selected a reviewer within twenty (20) days of the dispute request, the commissioner shall, within ten (10) days, select a qualified reviewer from his or her list of qualified reviewers established under subsection (2) of this section.***

***4. The reviewer's fees shall be split evenly and paid by the insurer and the nonparticipating provider.***

***(6) (a) Within thirty (30) days from the date of the dispute request submitted under subsection (3) of this section, the parties shall participate in an informal settlement conference to attempt to settle the dispute. A reviewer shall not participate in the informal settlement conference.***

***(b) The nonparticipating provider shall notify the commissioner whether the parties reached a settlement within five (5) days of completion of the conference.***

***(7) The parties shall not be entitled to engage in discovery in connection with the independent dispute resolution program.***

***(8) The reviewer shall:***

***(a) Set a date for the submission of all information to be considered by the reviewer;***

***(b) Except as provided in subsection (11) of this section, hold in strict confidence all information provided by a party and all communications of the reviewer with the parties; and***

***(c) Not later than sixty (60) days after the date of the dispute request submitted under subsection (3) of this section, provide the parties with a written decision that:***

***1. Determines the reasonable amount owed to the nonparticipating provider for the unanticipated out-of-network care; and***

***2. Selects, as the amount awarded under this section, the amount determined under subparagraph 1. of this paragraph.***

***(9) The reviewer's determination under subsection (8)(c) of this section:***

***(a) Shall take into account:***

***1. Whether there is a gross disparity between the charges billed by the nonparticipating provider and:***

***a. Reimbursements paid to the nonparticipating provider for the same health care service rendered by the provider to other insureds for which the provider is a nonparticipating provider; and***

***b. Reimbursements paid by the insurer to reimburse similarly qualified nonparticipating providers for the same health care services in the same geographic region;***

***2. The level of training, education, and experience of the nonparticipating provider;***

***3. The nonparticipating provider's historical data, for charges billed and reimbursements received, for comparable health care services with regard to other insureds;***

***4. The circumstances and complexity of the insured's particular case,***

***including the time and place of the provision of health care services;***

***5. The insured's medical conditions, co-morbidities, and other medical characteristics;***

***6. The current and historical data for the usual and customary rate of the health care service provided, which shall be:***

***a. Except as provided in subdivision b. of this subparagraph, the lesser of the following:***

***i. The usual and customary rate for the health care service provided for the current year; or***

***ii. The usual and customary rate for the health care service provided for the year 2023; or***

***b. If there is not data available for the year 2023, the usual and customary rate for the health care service provided for the current year; and***

***7. The history of network contracting between the parties; and***

***(b) May take into account any other information relevant to the value of the health care service provided.***

***(10) Except as provided in subsection (13) of this section, any deadline under this section may be extended by agreement of the parties.***

***(11) A reviewer shall provide a report to the commissioner, in a form and manner prescribed by the commissioner, of each amount awarded under this section.***

***(12) Not later than thirty (30) days after the date of the reviewer's decision, an insurer shall pay the nonparticipating provider any amount necessary to satisfy the amount awarded by the reviewer under this section.***

***(13) Within forty-five (45) days of a reviewer's decision under this section, a party may file a civil action to determine the amount owed, if any, by the insurer to the nonparticipating provider for unanticipated out-of-network care.***

***(14) Information submitted by the parties to the reviewer shall not be subject to public disclosure under KRS 61.800 to 61.878.***

***(15) Nothing in this section shall be construed to limit the admissibility, in any civil action, of the reviewer's determination or the information provided during the independent dispute resolution process.***

➔SECTION 5. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) Any health plan or health plan sponsor not otherwise required to comply with Section 2 of this Act may elect, on an annual basis, to submit to the department all billed charges received from both participating and nonparticipating providers for each health care service.***

***(2) Any health plan or health plan sponsor not otherwise required to comply with Sections 3 and 4 of this Act may elect, on an annual basis, for Sections 3 and 4 of this Act to apply to the plan.***

***(3) A health plan or health plan sponsor making one (1) or more elections under this section shall provide written notice of each election to the commissioner, in the form and manner prescribed by the commissioner.***

***(4) Sections 3 and 4 of this Act shall not apply to a provider for unanticipated out-of-network care, as defined in Section 3 of this Act, provided to an insured of any health plan or health plan sponsor not otherwise required to comply with Sections 3 and 4 of this Act unless such plan or sponsor provides written notice under subsection (3) of this section of its election to have Sections 3 and 4 of this Act apply to the plan.***

➔SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) An insurer shall provide written notice of any claim made for unanticipated out-of-network care, as defined in Section 3 of this Act, in an explanation of benefits,***

***provided to the insured and the nonparticipating provider, in a format prescribed by the commissioner, which shall include:***

***(a) A statement of the balance billing prohibition in Section 3 of this Act; and***

***(b) For an explanation of benefits provided to a nonparticipating provider, information, as prescribed by the commissioner, relating to the provider's rights under Section 4 of this Act.***

***(2) The insurer shall provide the explanation of benefits, with the notices required under this section, not later than the date an insurer makes a reimbursement under Section 3 of this Act.***

➔Section 7. KRS 304.17A-505 is amended to read as follows:

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

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

(a) Covered services and benefits to which the enrollee or other covered person is entitled;

(b) Restrictions or limitations on covered services and benefits;

(c) Financial responsibility of the covered person, including copayments and deductibles;

(d) Prior authorization and any other review requirements with respect to accessing covered services;

(e) Where and in what manner covered services may be obtained;

(f) Changes in covered services or benefits, including any addition, reduction, or

elimination of specific services or benefits;

(g) The covered person's right to the following:

1. A utilization review and the procedure for initiating a utilization review, if an insurer elects to provide utilization review;

2. An internal appeal of a utilization review made by or on behalf of the insurer with respect to the denial, reduction, or termination of a health care benefit or the denial of payment for a health care service, and the procedure to initiate an internal appeal; and

3. An external review and the procedure to initiate the external review process;

(h) Measures in place to ensure the confidentiality of the relationship between an enrollee and a health care provider;

(i) Other information as the commissioner shall require by administrative regulation;

(j) A summary of the drug formulary, including, but not limited to, a listing of the most commonly used drugs, drugs requiring prior authorization, any restrictions, limitations, and procedures for authorization to obtain drugs not on the formulary and, upon request of an insured or enrollee, a complete drug formulary; ~~[and]~~

(k) A statement informing the insured or enrollee that if the provider meets the insurer's enrollment criteria and is willing to meet the terms and conditions for participation, the provider has the right to become a provider for the insurer**;** ***and***

***(l) A statement informing the insured or enrollee that:***

***1. Some health care providers may not be included in the health benefit plan's provider network; and***

***2. Nonparticipating providers may balance bill covered persons for***

***amounts not paid by the health benefit plan unless the health care services are subject to the balance billing prohibition under Section 3 of this Act***.

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

➔SECTION 8. A NEW SECTION OF KRS CHAPTER 365 IS CREATED TO READ AS FOLLOWS:

***(1) If the Attorney General receives a referral from the commissioner of insurance indicating that any person has exhibited a pattern of intentionally violating Section 3 of this Act, the Attorney General may bring a civil action in the name of the Commonwealth to enjoin the person from the violation.***

***(2) If the Attorney General prevails in an action brought under this section, the Attorney General may recover attorney's fees, costs, and expenses, including court costs and witness fees, incurred in bringing the action.***

***(3) Nothing in this section shall be construed to prevent an insured from bringing an action to enforce the protections against balance billing set forth in Section 3 of this Act.***

➔Section 9. KRS 18A.225 (Effective April 1, 2021) 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, County Employees Retirement System, 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; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

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, County Employees Retirement System, 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 statutorily 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 or her place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he or she 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 or she 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 the secretary's 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 ***the effective date of this Act***~~[July 12, 2006]~~, to public employees pursuant to this section shall comply with***:***

***(a) Sections 3 and 4 of this Act;***

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

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

***(d) KRS 205.593;***

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

***(f) KRS 304.14-135;***

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

***(h) KRS 304.99-123;***

***(i) KRS 304.17A-138; and***

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

~~(23) Any fully 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.~~

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

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

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

(2) The following restrictions shall be applied in calculating the permissible amount or rate of premiums for an employer-organized association health insurance plan issued to an employer-organized association as defined in KRS 304.17A-005***(14)***~~[(12)]~~(a) to (c):

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

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

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

2. Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating period of less than one (1) year, due to the

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

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

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

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

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

➔Section 11. 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 12. 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);

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

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

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

***(7)*** ~~[(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;

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

~~(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;

***(9)*** ~~[(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;

***(10)*** ~~[(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;

***(11)*** ~~[(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

***(12)*** ~~[(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 13. KRS 304.17A-550 is amended to read as follows:

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

***(b)*** ***Except as provided in Section 3 of this Act,*** the plan with out-of-network benefits may require that an enrollee pre-certify selected services and pay a higher deductible, copayment, coinsurance, excess charges and higher

premium for the out-of-network benefit plan pursuant to limits established by administrative regulations promulgated by the department.

(2) If the contract holder elects the out-of-network offering required under subsection (1) of this section, the insurer shall provide each enrollee with the opportunity at the time of enrollment and during the annual open enrollment period, to enroll in the out-of-network option. If the contract holder elects the out-of-network offering required under subsection (1) of this section, the insurer and the contract holder shall provide written notice of the benefit plan with out-of-network benefits to each enrollee in a plan and shall include in that notice a detailed explanation of the financial costs to be incurred by an enrollee who selects the plan.

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

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

➔Section 14. 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 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. An insurer shall be prohibited from denying the emergency department services and altering

the level of coverage or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition~~[ as defined in KRS 304.17A-500]~~.

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

(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.

➔Section 15. 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 16. 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~~[(29)]~~;

***(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)]~~ "Office" means the Office of Health Data and Analytics in the Cabinet for Health and Family Services;

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

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

***(25)*** ~~[(27)]~~ "Stop-loss carrier" means any person providing stop-loss health insurance coverage;

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

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

➔Section 17. 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 ***eligible*** individuals***,*** ***as defined in***~~[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 office;

(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 18. 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 director of the Division of Health Benefit Exchange. The director may accept or reject any or all of the recommendations and may make whatever changes by administrative regulation the director deems appropriate. The council, in making recommendations, and the director, 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 director may by administrative regulation add to or delete from the list of high-cost conditions for Kentucky Access.

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

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

➔Section 23. This Act shall take effect January 1, 2022.