AN ACT relating to consumer protections in health care.

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

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

(1) As used in this section:

(a) "Balance bill" refers to a health care provider billing a covered person for the remaining balance of the amount the provider charges for a service less the following:

1. The amount an insurer reimburses; and

2. Any applicable cost-sharing the covered person is required to pay;

(b) "Cost-sharing" means coinsurance, deductibles, copayments, and any other out-of-pocket expense requirements imposed under a health plan;

(c) "Covered person" means a person that is covered under a health plan;

(d) "Health care provider" has the same meaning as in KRS 304.17A-005;

(e) "Health care services":

1. Has the same meaning as in KRS 304.17A-005; and

2. Includes the treatment of an emergency medical condition, as defined in KRS 304.17A-500, and emergency department screening and stabilization services;

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

(g) "Health plan":

1. Means any policy, contract, or plan that offers or provides health insurance coverage in this state by an insurer to covered persons, whether such coverage is by direct payment, reimbursement, or otherwise; and

2. Includes a health benefit plan, as defined in KRS 304.17A-005;

(h) "Insurer" means any:

1. Insurance company;

2. Health maintenance organization;

3. Self-insurer, which shall include:

a. A governmental plan;

b. A church plan;

c. Multiple employer welfare arrangement; and

d. Any other self-insured plan or association, whether employer-organized or otherwise;

4. Provider-sponsored integrated health delivery network;

5. Nonprofit hospital, medical-surgical, dental, or health service corporation; or

6. Other third-party payor that provides coverage under a health plan;

(i) "Nonparticipating provider" means a health care provider that has not entered into an agreement with a covered person's insurer to provide health care services to the covered person;

(j) "Participating provider" means a health care provider that has entered into an agreement with a covered person's insurer to provide health care services to the covered person; and

(k) "Scheduled health care services" do not include the treatment of an emergency medical condition, as defined in KRS 304.17A-500, or emergency department screening and stabilization services.

(2) (a) A health care provider shall provide a good faith estimate of the amount that will be owed by a patient for scheduled health care services, unless the patient affirmatively declines to receive such an estimate, upon the earlier of the following:

1. At the time the health care services are scheduled to be rendered by the provider to the patient; or

2. Within forty-eight (48) hours of a request made by the patient for the good faith estimate.

(b) For scheduled health care services that are covered under a covered person's health plan, to the extent permitted by federal law:

1. A health care provider shall disclose in the good faith estimate:

a. For participating providers, the rate negotiated with the covered person's insurer or health plan for the scheduled health care services; or

b. For nonparticipating providers, the amount, if known, allowed for payment by the covered person's insurer or health plan for the scheduled health care services; and

2. A covered person's insurer shall provide a good faith estimate of the following within forty-eight (48) hours of a request made by the covered person or health care provider:

a. The amount of cost sharing, if any, that would be owed by the covered person for the scheduled health care services under the covered person's health plan; and

b. For nonparticipating providers, the amount allowed by the insurer for payment to the nonparticipating provider for scheduled health care services.

(c) A nonparticipating provider that fails to provide a good faith estimate in accordance with this subsection shall not balance bill a covered person for scheduled health care services that are covered under the covered person's health plan.

(3) A nonparticipating provider shall not balance bill a covered person for emergency medical conditions and emergency department screening and stabilization services covered under subsection (4) of Section 2 of this Act.

(4) To the extent permitted by federal law, no insurer, or health facility, shall represent that a health facility is a participating provider if:

(a) The health facility balance bills covered persons for health care services provided at the health facility; or

(b) The insurer, or health facility, permits other health care providers to balance bill covered persons for health care services provided at the health facility.

(5) (a) A violation of this section shall be deemed an unfair, false, misleading, or deceptive act or practice in the conduct of trade or commerce in violation of KRS 367.170.

(b) All of the remedies, powers, and duties delegated to the Attorney General by KRS 367.190 to 367.300 and penalties pertaining to acts and practices declared unlawful under KRS 367.170 shall be applied to acts and practices in violation of this section.

(c) The remedies provided in this section shall be in addition to any other remedies or penalties for any conduct provided for by common law or statute.

(d) The Attorney General may promulgate administrative regulations as he or she deems necessary for the proper administration of this section.

➔Section 2. KRS 304.17A-580 is amended to read as follows:

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

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

1. "Cost-sharing";

2. "Covered person";

3. "Health plan";

4. "Insurer";

5. "Nonparticipating provider"; and

6. "Participating provider"; and

(b) "Out-of-network facility" means a health facility that has not entered into an agreement with a covered person's insurer to provide health care services to the covered person.

(2) Except as provided in subsection (5) of this section and to the extent permitted by federal law:

(a) 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***; and***~~[.]~~

(b)~~[(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) (a) Except as otherwise provided in KRS 304.17A-641, for emergency medical conditions and emergency department screening and stabilization services covered pursuant to this section, if the emergency medical condition was treated or the screening and stabilization services were provided by a nonparticipating provider at an out-of-network facility, a covered person's

insurer shall:

1. Reimburse the nonparticipating provider at the greater of the following, less any cost-sharing owed by the covered person:

a. i. Except as provided under subparts ii. and iii. of this subdivision, the amount negotiated with participating providers for the emergency medical conditions and emergency department screening and stabilization services;

ii. If there is more than one (1) amount negotiated with participating providers for the emergency medical conditions and emergency department screening and stabilization services, the median of those amounts. In determining the median amount, the amount negotiated with each participating provider shall be treated as a separate payment amount, regardless of whether the same amount is paid to more than one (1) provider; or

iii. If there is no per-service amount negotiated with participating providers, such as under a capitation or other similar arrangement, this subdivision shall be disregarded when determining the reimbursement amount under this paragraph;

b. The amount for the emergency medical conditions and emergency department screening and stabilization services using the same method the health plan generally uses to determine payments for out-of-network services; or

c. The amount that would be paid under parts A or B of the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. secs. 1395c to 1395w-6, as amended, for the emergency

medical conditions and emergency department screening and stabilization services;

2. Send the reimbursement, if any, directly to the nonparticipating provider; and

3. Along with any reimbursement required under this subsection, notify the nonparticipating provider of any cost-sharing that is owed by the covered person for the emergency medical conditions and emergency department screening and stabilization services. The cost-sharing owed under this subparagraph shall not exceed the cost-sharing that would be owed by the covered person if the services were provided by a participating provider.

(b) Except as provided in paragraph (a) of this subsection relating to reimbursement rates, all claims and reimbursements covered by this subsection shall be subject to KRS 304.14-135, 304.17A-700 to 304.17A-730, and 304.99-123.

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

➔Section 3. KRS 304.12-020 is amended to read as follows:

(1) No person shall make or disseminate orally or in other manner any advertisement, information, matter, statement, or thing:

(a) ~~[(1)]~~ Misrepresenting the terms of any policy or the benefits or advantages thereof or dividends or share of surplus to be received thereon, or setting forth false or misleading information or estimates as to dividends or share of surplus previously paid on similar policies***;*** ~~[.]~~

(b) ~~[(2)]~~ Using any name or title of any policy or class of policies misrepresenting the true nature thereof***;*** ~~[.]~~

(c) ~~[(3)]~~ Setting forth any misleading representation or any misrepresentation as to the financial condition of an insurer, or as to the legal reserve system upon which any life insurer operates***; or*** ~~[.]~~

(d) ~~[(4)]~~ Containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(2) It shall be an unfair or deceptive trade practice for an insurer to violate Section 1 of this Act.

➔Section 4. Any provision of a contract issued, delivered, entered, renewed, extended, or amended on or after the effective date of this Act that is contrary to the provisions of this Act shall be void and unenforceable in this state.