

1 AN ACT relating to consumer protections in health insurance.

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

3 SECTION 1. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
4 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

5 *(1) The purpose of this subtitle is the protection of the interests of Kentuckians, and*
6 *enforcement of patient protections created by federal law through the Patient*
7 *Protection and Affordable Care Act and the Health Care and Education Reconciliation*
8 *Act of 2010 (collectively “ACA”).*

9 *(2) Any person or entity that provides health insurance coverage in the Commonwealth of*
10 *Kentucky that is subject to the requirements of ACA shall comply with the provisions*
11 *of this subtitle and the provisions in KRS chapter 304 and administrative regulations*
12 *promulgated thereunder not in conflict with this subtitle unless the person or other*
13 *entity demonstrates to the satisfaction of the commissioner that while providing such*
14 *services it is subject to the jurisdiction of another agency of this state, any subdivision*
15 *thereof, or the federal government.*

16 SECTION 2. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
17 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

18 *(1) “Adverse benefit determination” means a denial, reduction, or termination of benefits,*
19 *or failure to provide payment, in whole or in part, for a benefit, that is based on:*

20 *(a) A determination of an enrollee’s eligibility to participate in the plan;*

21 *(b) The application of any utilization review;*

22 *(c) A determination that a service is deemed experimental, investigational, or not*
23 *medically necessary; or*

1 (d) A rescission whether or not there is an adverse effect on any particular benefit
2 at the time of rescission.

3 (2) “Affordable Care Act” or “ACA” means the Patient Protection and Affordable Care
4 Act of 2010, Public Law 111-148, and the Health Care and Education Reconciliation
5 Act of 2010, Public Law 111-152.

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

9 (4) “Cost-sharing” means the portion of covered benefits that an enrollee is responsible
10 for paying under a health insurance policy including a copayment, co-insurance, or
11 deductible.

12 (5) “Dependent coverage” means coverage of any individual under the terms of group or
13 individual health insurance coverage because of the relationship to a participant or
14 primary subscriber.

15 (6) “Emergency medical condition” means a medical condition manifesting itself by acute
16 symptoms of sufficient severity, including severe pain, that a prudent layperson, who
17 possesses an average knowledge of health and medicine, could reasonably expect the
18 absence of immediate medical attention to result in:

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

21 (b) Serious impairment to bodily functions; or

22 (c) Serious dysfunction of any bodily organ or part.

23 (7) “Emergency services” means:

1 (a) A medical screening examination that is within the capability of the emergency
2 department of a hospital, including ancillary services routinely available to the
3 emergency department to evaluate the emergency medical condition, and

4 (b) Within the capabilities of the staff and facilities available at the hospital, the
5 further medical examination and treatment to stabilize the patient.

6 (8) "Enrollee" means a person who is enrolled in a health insurance policy offered by a
7 health insurance issuer.

8 (9) "Excepted benefits" means benefits under one (1) or more, or any combination
9 thereof, of the following:

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

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

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

15 (d) Workers' compensation or similar insurance;

16 (e) Automobile medical payment insurance;

17 (f) Credit-only insurance;

18 (g) Coverage for on-site medical clinics;

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

22 (i) Limited scope dental or vision benefits;

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

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

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

6 (m) Hospital indemnity or other fixed indemnity insurance;

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

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

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

13 (q) Health flexible spending arrangements;

14 (10) “External review” means a review of an adverse benefit determination conducted
15 pursuant to section 11 of this Act.

16 (11) “Grandfathered plan” means health insurance in which an individual was enrolled as
17 of March 23, 2010 and which complies with the requirements of Pub. L. 111-148,
18 section 1252 and the regulations promulgated thereunder.

19 (12) “Group health insurance” means health insurance offered to a small group or a large
20 group.

21 (13) “Health insurance” means benefits, provided directly, through insurance or
22 reimbursement, under any policy offered by a health insurance issuer which is not a
23 excepted benefits policy.

- 1 (14) “Health insurance issuer” means:
- 2 (a) an entity licensed to engage in the business of health insurance in Kentucky;
- 3 or
- 4 (b) a self-insured plan or multiple employer welfare arrangement not exempt from
- 5 state regulation by ERISA.
- 6 (15) “Individual health insurance” means health insurance offered to individuals other
- 7 than in connection with group health insurance. Individual health insurance includes
- 8 health insurance offered through a association that is not employer related, issued to
- 9 individuals on an individually underwritten basis.
- 10 (16) “Individual market” means the market for health insurance offered to individual
- 11 other than in connection with group health insurance.
- 12 (17) “Internal appeal” means review by a health insurance issuer of an adverse benefit
- 13 determination as set forth in section 11 of this Act.
- 14 (18) "Large group" means:
- 15 (a) An employer with fifty-one (51) or more employees; or
- 16 (b) An affiliated group or association with fifty-one (51) or more eligible members.
- 17 (19) “Market segment” means the portion of the market covering one of the following:
- 18 (a) Individual;
- 19 (b) Small group; or
- 20 (c) Large group.
- 21 (20) "Multiple employer welfare arrangement" or “MEWA” means a plan or arrangement
- 22 that is established or maintained for the purpose of offering or providing health

1 insurance to the employees of two or more employers. MEWA does not include a plan
2 or arrangement that is established or maintained:

3 (a) Under or pursuant to one or more agreements which the United States
4 Secretary of Labor finds to be collective bargaining agreements,

5 (b) By a rural electric cooperative, or

6 (c) By a rural telephone cooperative association.

7 (21) “Plan year” means:

8 (a) In the individual health insurance market:

9 1. The 12-month period that is designated as the policy year in the policy
10 documents of the individual health insurance coverage;

11 2. If there is no designation of a policy year in the policy document, or no
12 policy document is available, the deductible or limit year used under the
13 coverage; or

14 3. If deductibles or other limits are not imposed on a yearly basis, the
15 calendar year.

16 (b) In the group market, the 12-month period that is designated as the plan year in
17 the policy documents of the group plan.

18 (22) “Pre-existing condition exclusion” means a limitation or exclusion of benefits,
19 including a denial of coverage, based on the fact that the condition was present
20 before the effective date of coverage or the date of denial under group or individual
21 health insurance coverage whether or not any medical advice, diagnosis, care, or
22 treatment was received or recommended before that day.

23 (23) “Rescind” means to retroactively cancel a health insurance policy.

1 (24) “Secretary” means the Secretary of the United States Department of Health and
2 Human Services.

3 (25) “Self-insured plan” means a group health insurance plan in which the sponsoring
4 organization assumes the financial risk of paying for covered services provided to the
5 enrollees.

6 (26) "Small group" means:

7 (a) A employer with one (1) to fifty (50) employees; or

8 (b) An affiliated group or association with one (1) to fifty (50) eligible members.

9 (27) “Stabilize” means to provide medical treatment of the emergency medical condition as
10 may be necessary to assure, within reasonable medical probability, that no material
11 deterioration of the emergency medical condition is likely to result from or occur
12 during the transfer of the individual from a facility.

13 SECTION 3. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
14 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

15 (1) A health insurance issuer offering group or individual health insurance coverage
16 which provides dependent coverage shall continue to make coverage available for an
17 adult child until the attainment of age twenty-six (26).

18 (2) Notwithstanding subsection (1) of this section, for a group grandfathered health plan,
19 a health insurance issuer shall not be required to provide dependent coverage for an
20 adult child who is eligible to enroll in an employer-sponsored health plan, as defined in
21 section 5000A(f)(2) of the Internal Revenue Code of 1986, other than the group health
22 plan of a parent.

1 (3) Nothing in this section shall require a health insurance issuer to make coverage
2 available for the child of a child receiving dependent coverage.

3 SECTION 4. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
4 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

5 (1) A health insurance issuer shall not impose a preexisting condition exclusion against
6 an individual to the attainment of age nineteen (19).

7 (2) Subsection (1) of this section shall not apply to a grandfathered plan.

8 SECTION 5. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
9 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

10
11 (1) Except for failure to timely pay a required premium or contribution, a health
12 insurance issuer shall not rescind a health insurance policy once coverage is effective,

13 unless:

14 (a) The enrollee or a person seeking coverage on behalf of the enrollee performs
15 an act, practice or omission that constitutes fraud; or

16 (b) The enrollee makes an intentional misrepresentation of material fact, as
17 prohibited by the terms of the health insurance policy.

18 (2) A health insurance policy shall only be rescinded in accordance with this subsection
19 upon thirty (30) days prior written notice to an affected enrollee, in accordance with
20 45 C.F.R. §147.128 (2010).

21 SECTION 6. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
22 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

23 (1) A health insurance issuer shall not establish a lifetime limit on the dollar value of
24 benefits for any enrollee.

1 (2) With respect to plan years beginning prior to January 1, 2014, a health insurance
2 issuer may establish, for any enrollee, an annual limit on the dollar amount of benefits
3 that are essential health benefits, provided the limit is in compliance with 42 C.F.R. §
4 147.126 (2010). An individual grandfathered plan shall not be subject to any limitation
5 on the establishment of an annual limit on the dollar amount of benefits for an
6 enrollee.

7 (3) Nothing in this section shall be construed to prevent an issuer from:

8 (a) Excluding all benefits for a specific condition whether for an essential or for a
9 non-essential health benefit; or

10 (b) Placing annual or lifetime per enrollee limits on specific covered benefits that
11 are not essential health benefits to the extent that limits are otherwise permitted
12 under federal or state law.

13 SECTION 7. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
14 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

15 (1) A health insurance issuer shall provide benefits for and not impose any cost sharing
16 requirements on preventive services including:

17 (a) Evidence-based items or services that have in effect a rating of A or B in the
18 current recommendations of the United States Preventive Services Task Force
19 with respect to the individual involved except as provided 45 C.F.R § 147.130
20 (2010);

21 (b) Immunizations for routine use in children, adolescents, and adults that have in
22 effect a recommendation from the Advisory Committee on Immunization
23 Practices of the Centers for Disease Control and Prevention with respect to the

1 individual involved if it is listed on the Immunization Schedules of the Centers
2 for Disease Control and Prevention;

3 (c) With respect to infants, children, and adolescents, evidence-informed preventive
4 care and screenings provided for in comprehensive guidelines supported by the
5 Health Resources and Services Administration;

6 (d) With respect to women, to the extent not described in paragraph (a) of this
7 subsection, evidence-informed preventive care and screenings provided for in
8 comprehensive guidelines supported by the Health Resources and Services
9 Administration; and

10 (e) Any other preventative services set forth in ACA and the regulations issued
11 thereunder.

12 (2) Subsection (1) of this section shall not apply to:

13 (a) A grandfathered plan; or

14 (b) Services delivered by an out-of-network provider if a health insurance policy
15 utilizes a network of providers.

16 SECTION 8. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
17 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

18 (1) On or after March 23, 2012 and prior to any enrollment restriction, a health insurance
19 issuer shall provide a summary of benefits and coverage explanation to:

20 (a) An applicant at the time of application;

21 (b) An enrollee prior to the time of enrollment or re-enrollment, as applicable; and

22 (c) A policyholder or certificate holder at the time of issuance of the policy or
23 delivery of the certificate.

- 1 (2) A summary of benefits and coverage explanation shall:
2 (a) Be presented in a uniform format in accordance with [New federal regulation];
3 (b) Utilize terminology understandable by the average plan enrollee.
4 (3) A summary of benefits and coverage explanation shall not:
5 (a) Include print small than twelve (12) point font; and
6 (b) Exceed four (4) pages in length
7 (4) If a health insurance issuer makes a material modification to the benefits covered
8 under the health insurance policy, the health insurance issuer shall give enrollees sixty
9 (60) days advance written notice.

10 SECTION 9. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
11 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

- 12 (1) On or after March 23, 2012, a health insurance issuer shall transmit at least annually
13 to the commissioner the information required by ACA section 2717 and the regulations
14 issued thereunder.
15 (2) A health insurance issuer shall make available the information required under
16 subsection (1) to an enrollee or applicant during each open enrollment period.

17 SECTION 10. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
18 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

- 19 (1) Beginning no later than January 1, 2011, a health insurance issuer shall provide to the
20 Secretary and commissioner, with respect each plan year, a report concerning the
21 medical loss ratio for the following market segments:
22 (a) Large group; and
23 (b) Small group and individual.

- 1 (2) A health insurance issuer shall provide with respect to each plan year an annual
2 refund to each enrollee under the coverage on a pro-rata basis if the medical loss ratio
3 is less than:
4 (a) With respect to the large group market, 85 percent; or
5 (b) With respect to the small group or individual market, 80 percent.
6 (3) (a) The commissioner may increase the percentages in subsection (2) of this section
7 by administrative regulation.
8 (b) The commissioner may adjust the percentages in subsection (2) of this section
9 by administrative regulation, in accordance with a determination by the
10 secretary.
11 (4) The commissioner may promulgate an administrative regulation to establish the
12 process for calculating and paying the refund set forth in this section.

13 SECTION 11. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
14 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

- 15 (1) A health insurance issuer shall implement an internal appeals process for appeals of
16 adverse benefit determinations, under which the plan or issuer shall, at a minimum
17 (a) 1. Have in effect an internal appeals process that incorporates the appeals
18 procedures set forth in 29 CFR 2560.503-1 and the requirements of
19 KRS 304.17A-600 through 304.17A-633 and the administrative
20 regulations promulgated thereunder; or
21 2. Shall update this process in accordance with any standards established
22 by the U.S. Secretary of Labor or the Secretary of Health and Human
23 Services;

1 (b) Provide notice to enrollees of available internal and external appeals processes
2 and the availability of the department to assist an enrollee with the appeals
3 processes; and

4 (c) Allow an enrollee to review his or her file, to present evidence and testimony as
5 part of the appeals process, and to receive continued coverage pending the
6 outcome of the appeals process.

7 (2) A health insurance issuer shall implement an external appeals process for appeals of
8 coverage determinations under which the plan or issuer shall, at a minimum, comply
9 with the external review process as established in KRS 304.17A-600 through KRS
10 304.17A-633 and the administrative regulations promulgated thereunder.

11 (3) This section shall not apply to a grandfathered plan.

12 SECTION 12. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
13 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

14 (1) A health insurance issuer shall:

15 (a) Permit an enrollee to choose a primary care provider from a list of health care
16 providers within the applicable network of providers;

17 (b) Permit an enrollee who is a child to designate a physician who specializes in
18 pediatrics as the child's primary care provider if the provider participates in the
19 applicable network of providers;

20 (c) Not require prior authorization or referral in the case of a female enrollee who
21 seeks coverage for obstetrical or gynecological treatment and service provided
22 by a participating health care provider who specializes in obstetrics or
23 gynecology; and

1 (d) Provide notice to each enrollee of the right to designate a provider in
2 accordance with paragraphs (a) through (c) of this subsection when an enrollee
3 is provided with a description of benefits.

4 (2) If a health insurance issuer provides benefits for emergency services, the issuer shall
5 provide benefits in the following manner:

6 (a) Without the need for any prior authorization determination, even if the
7 emergency services are provided on an out-of-network basis;

8 (b) Without regard to whether the health care provider furnishing the emergency
9 services is a participating provider with respect to the services;

10 (c) If the emergency services are provided out-of-network, without imposing any
11 administrative requirement or limitation on coverage that is more restrictive
12 than the requirements or limitations that apply to emergency services received
13 in-network;

14 (d) If the emergency services are provided out-of-network, by complying with the
15 following cost-sharing requirements:

16 1. Out-of-Network cost-sharing cannot exceed the cost-sharing
17 requirements imposed with respect to an enrollee if the services were
18 provided in-network; and

19 2. In addition to the in-network cost-sharing, an enrollee may be required
20 to pay to the out-of-network provider the amount of the provider's
21 charges which is not reimbursed by the issuer; and

22 (e) Without regard to any other term or condition, other than:

23 1. The exclusion of benefits;

1 2. *Coordination of benefits*

2 3. *An affiliation or waiting period; or*

3 4. *Applicable cost sharing.*

4 (3) *Nothing in this section shall be construed to waive any exclusions of coverage under*
5 *the terms and conditions of the health insurance policy.*

6 (4) *This section shall not apply to a grandfathered plan.*

7 SECTION 13. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
8 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

9 (1) *Notwithstanding any other provision of Kentucky law, the commissioner may*
10 *promulgate administrative regulations necessary to implement and enforce the provisions of*
11 *this subtitle and the following federal statutes or regulations promulgated thereunder that*
12 *affect the rights and consumer protections of citizens of Kentucky:*

13 (a) *Public Protection and Affordable Care Act, Public Law 111-148; and*

14 (b) *Health Care and Education Affordability Reconciliation Act of 2010, Public*
15 *Law 111-152; and*

16 (2) *Any administrative regulation promulgated under this section shall be no more*
17 *stringent than the federal laws or regulations identified in subsection (1) of this*
18 *section.*

19 SECTION 14. SUBTITLE 17D OF KRS CHAPTER 304 IS ESTABLISHED AND A
20 NEW SECTION THEREOF IS CREATED TO READ AS FOLLOWS:

21 *The following provisions of this chapter to the extent applicable and not in conflict with the*
22 *expressed provisions of this subtitle shall also apply to health insurance issuers:*

23 (1) *Subtitle 1;*

- 1 (2) Subtitle 2;
- 2 (3) Subtitle 3;
- 3 (4) Subtitle 9;
- 4 (5) Subtitle 12;
- 5 (6) Subtitle 14;
- 6 (7) Subtitle 17;
- 7 (8) Subtitle 17A;
- 8 (9) Subtitle 18;
- 9 (10) Subtitle 32;
- 10 (11) Subtitle 38;
- 11 (12) Subtitle 47;
- 12 (13) Subtitle 99.

13 Section 15. KRS 304.17-030 is amended to read as follows:

14 No policy of health insurance shall be delivered or issued for delivery to any person in this state
15 unless it otherwise complies with this title, and complies with the following:

- 16 (1) The entire money and other considerations therefor shall be expressed therein;
- 17 (2) The time when the insurance takes effect and terminates shall be expressed therein;
- 18 (3) It shall purport to insure only one (1) person, except that a policy may insure, originally
19 or by subsequent amendment, upon the application of an adult member of a family, who
20 shall be deemed the policyholder, any two (2) or more eligible members of that family,
21 including husband, wife, unmarried dependent children to age nineteen (19), unmarried
22 children from nineteen (19) to twenty-five (25) years of age who are full-time students
23 enrolled in and attending an accredited educational institution and who are primarily

1 dependent on the policyholder for maintenance and support, and any other person
2 dependent upon the policyholder as provided pursuant to KRS 304.17-310;

3 (4) The style, arrangement, and overall appearance of the policy shall give no undue
4 prominence to any portion of the text, and every printed portion of the text of the policy
5 and of any indorsements or attached papers shall be plainly printed in light-faced type of
6 a style in general use, the size of which shall be uniform and not less than ten (10) point
7 with a lower case unspaced alphabet length not less than one hundred and twenty (120)
8 point (the "text" shall include all printed matter except the name and address of the
9 insurer, name on title of the policy, the brief description, if any, and captions and
10 subcaptions);

11 (5) The exceptions and reductions of indemnity shall be set forth in the policy and other than
12 those contained in KRS 304.17-050 to 304.17-290, inclusive, shall be printed, at the
13 insurer's option, either included with the benefit provision to which they apply, or under
14 an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that
15 if an exception or reduction specifically applies only to a particular benefit of the policy,
16 a statement of the exception or reduction shall be included with the benefit provision to
17 which it applies;

18 (6) Each form, including riders and indorsements, shall be identified by a form number in the
19 lower left-hand corner of the first page thereof; and

20 (7) The policy shall contain no provision purporting to make any portion of the charter, rules,
21 constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in
22 full in the policy, except in the case of the incorporation of, or reference to, a statement of
23 rates or classification of risks, or short-rate table filed with the commissioner.

1 **(8) Notwithstanding subsection (3) of this section, insurers offering health benefit plans**
2 **shall comply with the requirements of Section 3 of this Act.**

3 Section 16. KRS 304.17-310 is amended to read as follows:

- 4 (1) Family expense health insurance is that provided under a policy issued to one (1) of the
5 family members insured, who shall be deemed the policyholder, covering any two (2) or
6 more eligible members of a family, including husband, wife, unmarried dependent
7 children, to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25)
8 years of age who are full-time students enrolled in and attending an accredited
9 educational institution and who are primarily dependent on the policyholder for
10 maintenance and support, and any other person dependent upon the policyholder. Any
11 authorized health insurer may issue the insurance.
- 12 (2) An individual hospital or medical expense insurance policy or hospital or medical service
13 plan contract delivered or issued for delivery in this state more than 120 days after June
14 13, 1968, which provides that coverage of a dependent child shall terminate upon
15 attainment of the limiting age for dependent children specified in the policy or contract
16 shall also provide in substance that attainment of the limiting age shall not operate to
17 terminate the coverage of the child while the child is and continues to be both (a)
18 incapable of self-sustaining employment by reason of mental retardation or physical
19 disability and (b) chiefly dependent upon the policyholder or subscriber for support and
20 maintenance, provided proof of the incapacity and dependency is furnished to the insurer
21 or corporation by the policyholder or subscriber within thirty-one (31) days of the child's
22 attainment of the limiting age and subsequently as may be required by the insurer or

1 corporation but not more frequently than annually after the two (2) year period following
2 the child's attainment of the limiting age.

3 (3) Insurers offering family expense health insurance shall offer the applicant the option to
4 purchase coverage for unmarried dependent children until age twenty-five (25).

5 **(4) Notwithstanding subsection (3) of this section, insurers offering health benefit plans**
6 **shall comply with the requirements of Section 3 of this Act.**

7 Section 17. KRS 304.17A-005 is amended to read as follows:

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

9 **(1) "Adverse benefit determination" or "adverse determination" means a denial,**
10 **reduction, or termination of benefits, or failure to provide payment in whole or in part**
11 **for a benefit, that is based on:**

12 **(a) A determination of an enrollee's eligibility to participate in a health benefit**
13 **plan;**

14 **(b) The application of any utilization review;**

15 **(c) A determination that a service is deemed experimental, investigational, or not**
16 **medically necessary;**

17 **(d) A coverage denial; or**

18 **(d) A rescission, whether or not there is an adverse effect on any particular benefit**
19 **at the time of rescission**

20 **(2) [(4)] "Association" means an entity, other than an employer-organized association, that has been**
21 **organized and is maintained in good faith for purposes other than that of obtaining insurance**
22 **for its members and that has a constitution and bylaws;**

23 **(3) [(2)] "At the time of enrollment" means:**

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

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

6 (4) [~~(3)~~] "Base premium rate" means, for each class of business as to a rating period, the lowest
7 premium rate charged or that could have been charged under the rating system for that class
8 of business by the insurer to the individual or small group, or employer as defined in KRS
9 304.17A-0954, with similar case characteristics for health benefit plans with the same or
10 similar coverage;

11 (5) [~~(4)~~] "Basic health benefit plan" means any plan offered to an individual, a small group, or
12 employer-organized association that limits coverage to physician, pharmacy, home health,
13 preventive, emergency, and inpatient and outpatient hospital services in accordance with the
14 requirements of this subtitle. If vision or eye services are offered, these services may be
15 provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by
16 providers licensed pursuant to KRS Chapter 312;

17 (6) [~~(5)~~] "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

18 (7) [~~(6)~~] "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

19 (8) [~~(7)~~] "COBRA" means any of the following:

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

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

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

24 (9) [~~(8)~~] (a) "Creditable coverage" means, with respect to an individual, coverage of the
25 individual under any of the following:

- 1 1. A group health plan;
- 2 2. Health insurance coverage;
- 3 3. Part A or Part B of Title XVIII of the Social Security Act;
- 4 4. Title XIX of the Social Security Act, other than coverage consisting solely of
5 benefits under section 1928;
- 6 5. Chapter 55 of Title 10, United States Code, including medical and dental care
7 for members and certain former members of the uniformed services, and for
8 their dependents; for purposes of Chapter 55 of Title 10, United States Code,
9 "uniformed services" means the Armed Forces and the Commissioned Corps
10 of the National Oceanic and Atmospheric Administration and of the Public
11 Health Service;
- 12 6. A medical care program of the Indian Health Service or of a tribal
13 organization;
- 14 7. A state health benefits risk pool;
- 15 8. A health plan offered under Chapter 89 of Title 5, United States Code, such
16 as the Federal Employees Health Benefit Program;
- 17 9. A public health plan as established or maintained by a state, the United States
18 government, a foreign country, or any political subdivision of a state, the
19 United States government, or a foreign country that provides health coverage
20 to individuals who are enrolled in the plan;
- 21 10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C.
22 sec. 2504(e)); or
- 23 11. Title XXI of the Social Security Act, such as the State Children's Health
24 Insurance Program.

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

3 (10) [~~(9)~~] "Dependent" means any individual who is or may become eligible for coverage under the
4 terms of an individual or group health benefit plan because of a relationship to a participant;

5 (11) [~~(10)~~] "Employee benefit plan" means an employee welfare benefit plan or an employee pension
6 benefit plan or a plan which is both an employee welfare benefit plan and an employee
7 pension benefit plan as defined by ERISA;

8 (12) [~~(11)~~] "Eligible individual" means an individual:

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

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

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

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

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

3 (13) [~~(12)~~] "Employer-organized association" means any of the following:

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

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

9 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3),
10 whose members consist principally of employers, and for which the entity's health
11 insurance decisions are made by a board or committee, the majority of which are
12 representatives of employer members of the entity who obtain group health insurance
13 coverage through the entity or through a trust or other mechanism established by the
14 entity, and whose health insurance decisions are reflected in written minutes or other
15 written documentation.

16 Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, no employer-
17 organized association shall be treated as an association, small group, or large group under this
18 subtitle;

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

24 (15) [~~(14)~~] "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of
25 the following:

- 1 (a) Coverage only for accident, including accidental death and dismemberment, or
2 disability income insurance, or any combination thereof;
- 3 (b) Coverage issued as a supplement to liability insurance;
- 4 (c) Liability insurance, including general liability insurance and automobile liability
5 insurance;
- 6 (d) Workers' compensation or similar insurance;
- 7 (e) Automobile medical payment insurance;
- 8 (f) Credit-only insurance;
- 9 (g) Coverage for on-site medical clinics;
- 10 (h) Other similar insurance coverage, specified in administrative regulations, under
11 which benefits for medical care are secondary or incidental to other insurance
12 benefits;
- 13 (i) Limited scope dental or vision benefits;
- 14 (j) Benefits for long-term care, nursing home care, home health care, community-based
15 care, or any combination thereof;
- 16 (k) Such other similar, limited benefits as are specified in administrative regulations;
- 17 (l) Coverage only for a specified disease or illness;
- 18 (m) Hospital indemnity or other fixed indemnity insurance;
- 19 (n) Benefits offered as Medicare supplemental health insurance, as defined under section
20 1882(g)(1) of the Social Security Act;
- 21 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
22 United States Code;
- 23 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
24 supplemental to coverage under a group health plan; and
- 25 (q) Health flexible spending arrangements;

- 1 (16) [(15)] "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);
- 2 (17) [(16)] "Group health plan" means a plan, including a self-insured plan, of or contributed to by an
- 3 employer, including a self-employed person, or employee organization, to provide health care
- 4 directly or otherwise to the employees, former employees, the employer, or others associated
- 5 or formerly associated with the employer in a business relationship, or their families;
- 6 (18) [(17)] "Guaranteed acceptance program participating insurer" means an insurer that is required
- 7 to or has agreed to offer health benefit plans in the individual market to guaranteed
- 8 acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;
- 9 (19) [(18)] "Guaranteed acceptance program plan" means a health benefit plan in the individual
- 10 market issued by an insurer that provides health benefits to a guaranteed acceptance program
- 11 qualified individual and is eligible for assessment and refunds under the guaranteed
- 12 acceptance program under KRS 304.17A-400 to 304.17A-480;
- 13 (20) [(19)] "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program
- 14 established and operated under KRS 304.17A-400 to 304.17A-480;
- 15 (21) [(20)] "Guaranteed acceptance program qualified individual" means an individual who, on or
- 16 before December 31, 2000:
- 17 (a) Is not an eligible individual;
- 18 (b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse
- 19 or a dependent of an individual who:
- 20 1. Waived coverage under KRS 304.17A-210(2); or
- 21 2. Did not elect family coverage that was available through the association or
- 22 group market;
- 23 (c) Within the previous three (3) years has been diagnosed with or treated for a high-cost
- 24 condition or has had benefits paid under a health benefit plan for a high-cost
- 25 condition, or is a high risk individual as defined by the underwriting criteria applied

1 by an insurer under the alternative underwriting mechanism established in KRS
2 304.17A-430(3);

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

5 (e) Has not had his or her most recent coverage under any health benefit plan terminated
6 or nonrenewed because of any of the following:

7 1. The individual failed to pay premiums or contributions in accordance with the
8 terms of the plan or the insurer had not received timely premium payments;

9 2. The individual performed an act or practice that constitutes fraud or made an
10 intentional misrepresentation of material fact under the terms of the coverage;

11 or

12 3. The individual engaged in intentional and abusive noncompliance with health
13 benefit plan provisions;

14 (22) [~~(21)~~] "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before
15 December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop
16 loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan
17 supporting insurer shall not include an employer-sponsored self-insured health benefit plan
18 exempted by ERISA;

19 (23) [~~(22)~~] "Health benefit plan" means any hospital or medical expense policy or certificate;
20 nonprofit hospital, medical-surgical, and health service corporation contract or certificate;
21 provider sponsored integrated health delivery network; a self-insured plan or a plan provided
22 by a multiple employer welfare arrangement, to the extent permitted by ERISA; health
23 maintenance organization contract; or any health benefit plan that affects the rights of a
24 Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued
25 for delivery in Kentucky, and does not include policies covering only accident, credit, dental,

1 disability income, fixed indemnity medical expense reimbursement policy, long-term care,
2 Medicare supplement, specified disease, vision care, coverage issued as a supplement to
3 liability insurance, insurance arising out of a workers' compensation or similar law,
4 automobile medical-payment insurance, insurance under which benefits are payable with or
5 without regard to fault and that is statutorily required to be contained in any liability
6 insurance policy or equivalent self-insurance, short-term coverage, student health insurance
7 offered by a Kentucky-licensed insurer under written contract with a university or college
8 whose students it proposes to insure, medical expense reimbursement policies specifically
9 designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a
10 separate policy, certificate, or contract, or coverage supplemental to the coverage provided
11 under Chapter 55 of Title 10, United States Code, or limited health service benefit plans;

12 (24) [~~(23)~~] "Health care provider" or "provider" means any facility or service required to be licensed
13 pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any
14 of the following independent practicing practitioners:

- 15 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;
- 16 (b) Chiropractors licensed under KRS Chapter 312;
- 17 (c) Dentists licensed under KRS Chapter 313;
- 18 (d) Optometrists licensed under KRS Chapter 320;
- 19 (e) Physician assistants regulated under KRS Chapter 311;
- 20 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and
- 21 (g) Other health care practitioners as determined by the department by administrative
22 regulations promulgated under KRS Chapter 13A;

23 (25) [~~(24)~~] (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program,
24 means a covered condition in an individual policy as listed in paragraph (c) of this
25 subsection or as added by the commissioner in accordance with KRS 304.17A-280,

1 but only to the extent that the condition exceeds the numerical score or rating
2 established pursuant to uniform underwriting standards prescribed by the
3 commissioner under paragraph (b) of this subsection that account for the severity of
4 the condition and the cost associated with treating that condition.

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

- 8 1. Codes in the most recent version of the "International Classification of
9 Diseases" that correspond to the medical conditions in paragraph (c) of this
10 subsection and the costs for administering treatment for the conditions
11 represented by those codes; and
- 12 2. The most recent version of the questionnaire incorporated in a national
13 underwriting guide generally accepted in the insurance industry as designated
14 by the commissioner, the scoring scale for which shall be established by the
15 commissioner.

16 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
17 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary
18 insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia,
19 Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer,
20 motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis,
21 myotonia, open heart surgery, Parkinson's disease, polycystic kidney, psychotic
22 disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

23 (26) [~~25~~] "Index rate" means, for each class of business as to a rating period, the arithmetic average
24 of the applicable base premium rate and the corresponding highest premium rate;

1 (27) [~~(26)~~] "Individual market" means the market for the health insurance coverage offered to
2 individuals other than in connection with a group health plan. The individual market includes
3 an association plan that is not employer related, issued to individuals on an individually
4 underwritten basis, other than an employer-organized association or a bona fide association,
5 that has been organized and is maintained in good faith for purposes other than obtaining
6 insurance for its members and that has a constitution and bylaws;

7 (28) [~~(27)~~] "Insurer" means any insurance company; health maintenance organization; self-insurer or
8 multiple employer welfare arrangement not exempt from state regulation by ERISA;
9 provider-sponsored integrated health delivery network; self-insured employer-organized
10 association, or nonprofit hospital, medical-surgical, dental, or health service corporation
11 authorized to transact health insurance business in Kentucky;

12 (29) [~~(28)~~] "Insurer-controlled" means that the commissioner has found, in an administrative hearing
13 called specifically for that purpose, that an insurer has or had a substantial involvement in the
14 organization or day-to-day operation of the entity for the principal purpose of creating a
15 device, arrangement, or scheme by which the insurer segments employer groups according to
16 their actual or anticipated health status or actual or projected health insurance premiums;

17 (30) [~~(29)~~] "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

18 (31) [~~(30)~~] "Large group" means:

- 19 (a) An employer with fifty-one (51) or more employees; or
- 20 (b) An affiliated group with fifty-one (51) or more eligible members;

21 (32) [~~(31)~~] "Managed care" means systems or techniques generally used by third-party payors or their
22 agents to affect access to and control payment for health care services and that integrate the
23 financing and delivery of appropriate health care services to covered persons by
24 arrangements with participating providers who are selected to participate on the basis of
25 explicit standards for furnishing a comprehensive set of health care services and financial

1 incentives for covered persons using the participating providers and procedures provided for
2 in the plan;

3 **(33)** [~~(32)~~] "Market segment" means the portion of the market covering one (1) of the following:

- 4 (a) Individual;
- 5 (b) Small group;
- 6 (c) Large group; or
- 7 (d) Association;

8 **(34)** [~~(33)~~] "Participant" means any employee or former employee of an employer, or any member or
9 former member of an employee organization, who is or may become eligible to receive a
10 benefit of any type from an employee benefit plan which covers employees of the employer
11 or members of the organization, or whose beneficiaries may be eligible to receive any benefit
12 as established in Section 3(7) of ERISA;

13 **(35)** [~~(34)~~] "Preventive services" means medical services for the early detection of disease that are
14 associated with substantial reduction in morbidity and mortality;

15 **(36)** [~~(35)~~] "Provider network" means an affiliated group of varied health care providers that is
16 established to provide a continuum of health care services to individuals;

17 **(37)** [~~(36)~~] "Provider-sponsored integrated health delivery network" means any provider-sponsored
18 integrated health delivery network created and qualified under KRS 304.17A-300 and KRS
19 304.17A-310;

20 **(38)** [~~(37)~~] "Purchaser" means an individual, organization, employer, association, or the
21 Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

22 **(39)** [~~(38)~~] "Rating period" means the calendar period for which premium rates are in effect. A rating
23 period shall not be required to be a calendar year;

1 (40) [(39)] "Restricted provider network" means a health benefit plan that conditions the payment of
2 benefits, in whole or in part, on the use of the providers that have entered into a contractual
3 arrangement with the insurer to provide health care services to covered individuals;

4 (41) [(40)] "Self-insured plan" means a group health insurance plan in which the sponsoring
5 organization assumes the financial risk of paying for covered services provided to its
6 enrollees;

7 (42) [(41)] "Small employer" means, in connection with a group health plan with respect to a
8 calendar year and a plan year, an employer who employed an average of at least two (2) but
9 not more than fifty (50) employees on business days during the preceding calendar year and
10 who employs at least two (2) employees on the first day of the plan year;

11 (43) [(42)] "Small group" means:

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

14 (44) [(43)] "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

15 (45) [(44)] "Telehealth" has the meaning provided in KRS 311.550.

16 Section 18. KRS 304.17A-256 is amended to read as follows:

17 (1) All [group] health benefit plans which provide dependent benefits shall **provide for**
18 **coverage of a dependent child until age twenty-six (26).** [~~offer the master policyholder~~
19 ~~the following two (2) options to purchase coverage for an unmarried dependent child:~~

20 (a) ~~Coverage until age nineteen (19) and coverage to unmarried children from~~
21 ~~nineteen (19) to twenty five (25) years of age who are full-time students enrolled~~
22 ~~in and attending an accredited educational institution and who are primarily~~
23 ~~dependent on the policyholder for maintenance and support; and~~

24 (b) ~~Coverage until age twenty five (25).~~

1 ~~(2) — The offer of coverage under paragraph (b) of subsection (1) of this section shall include a~~
2 ~~disclaimer that selecting either option may have tax implications.]~~

3 **(2) Notwithstanding subsection (1) of this section, for a group grandfathered health**
4 **benefit plan, an insurer shall not be required to provide coverage for a dependent child**
5 **who is eligible to enroll in an eligible employer-sponsored health plan as defined in**
6 **section 5000A(f)(2) of the Internal Revenue Code of 1986.**

7 Section 19. KRS 304.17A-220 is amended to read as follows:

8 (1) All group health plans and insurers offering group health insurance coverage in the
9 Commonwealth shall comply with the provisions of this section.

10 (2) Subject to subsection (8) of this section, a group health plan, and a health insurance
11 insurer offering group health insurance coverage, may, with respect to a participant or
12 beneficiary, impose a pre-existing condition exclusion only if:

13 (a) The exclusion relates to a condition, whether physical or mental, regardless of the
14 cause of the condition, for which medical advice, diagnosis, care, or treatment
15 was recommended or received within the six (6) month period ending on the
16 enrollment date. For purposes of this paragraph:

17 1. Medical advice, diagnosis, care, or treatment is taken into account only if
18 it is recommended by, or received from, an individual licensed or similarly
19 authorized to provide such services under state law and operating within
20 the scope of practice authorized by state law; and

21 2. The six (6) month period ending on the enrollment date begins on the six
22 (6) month anniversary date preceding the enrollment date;

- 1 (b) The exclusion extends for a period of not more than twelve (12) months, or
2 eighteen (18) months in the case of a late enrollee, after the enrollment date;
- 3 (c) 1. The period of any pre-existing condition exclusion that would otherwise
4 apply to an individual is reduced by the number of days of creditable
5 coverage the individual has as of the enrollment date, as counted under
6 subsection (3) of this section; and
- 7 2. Except for ineligible individuals who apply for coverage in the individual
8 market, the period of any pre-existing condition exclusion that would
9 otherwise apply to an individual may be reduced by the number of days of
10 creditable coverage the individual has as of the effective date of coverage
11 under the policy; and
- 12 (d) A written notice of the pre-existing condition exclusion is provided to participants
13 under the plan, and the insurer cannot impose a pre-existing condition exclusion
14 with respect to a participant or a dependent of the participant until such notice is
15 provided.
- 16 (3) In reducing the pre-existing condition exclusion period that applies to an individual, the
17 amount of creditable coverage is determined by counting all the days on which the
18 individual has one (1) or more types of creditable coverage. For purposes of counting
19 creditable coverage:
- 20 (a) If on a particular day the individual has creditable coverage from more than one
21 (1) source, all the creditable coverage on that day is counted as one (1) day;
- 22 (b) Any days in a waiting period for coverage are not creditable coverage;

- 1 (c) Days of creditable coverage that occur before a significant break in coverage are
2 not required to be counted; and
- 3 (d) Days in a waiting period and days in an affiliation period are not taken into
4 account in determining whether a significant break in coverage has occurred.
- 5 (4) An insurer may determine the amount of creditable coverage in another manner than
6 established in subsection (3) of this section that is at least as favorable to the individual as
7 the method established in subsection (3) of this section.
- 8 (5) If an insurer receives creditable coverage information, the insurer shall make a
9 determination regarding the amount of the individual's creditable coverage and the length
10 of any pre-existing exclusion period that remains. A written notice of the length of the
11 pre-existing condition exclusion period that remains after offsetting for prior creditable
12 coverage shall be issued by the insurer. An insurer may not impose any limit on the
13 amount of time that an individual has to present a certificate or evidence of creditable
14 coverage.
- 15 (6) For purposes of this section:
- 16 (a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or
17 exclusion of benefits relating to a condition based on the fact that the condition
18 was present before the effective date of coverage, whether or not any medical
19 advice, diagnosis, care, or treatment was recommended or received before that
20 day. A pre-existing condition exclusion includes any exclusion applicable to an
21 individual as a result of information relating to an individual's health status before
22 the individual's effective date of coverage under a health benefit plan;

- 1 (b) "Enrollment date" means, with respect to an individual covered under a group
2 health plan or health insurance coverage, the first day of coverage or, if there is a
3 waiting period, the first day of the waiting period. If an individual receiving
4 benefits under a group health plan changes benefit packages, or if the employer
5 changes its group health insurer, the individual's enrollment date does not change;
- 6 (c) "First day of coverage" means, in the case of an individual covered for benefits
7 under a group health plan, the first day of coverage under the plan and, in the case
8 of an individual covered by health insurance coverage in the individual market,
9 the first day of coverage under the policy or contract;
- 10 (d) "Late enrollee" means an individual whose enrollment in a plan is a late
11 enrollment;
- 12 (e) "Late enrollment" means enrollment of an individual under a group health plan
13 other than:
- 14 1. On the earliest date on which coverage can become effective for the
15 individual under the terms of the plan; or
 - 16 2. Through special enrollment;
- 17 (f) "Significant break in coverage" means a period of sixty-three (63) consecutive
18 days during each of which an individual does not have any creditable coverage;
19 and
- 20 (g) "Waiting period" means the period that must pass before coverage for an
21 employee or dependent who is otherwise eligible to enroll under the terms of a
22 group health plan can become effective. If an employee or dependent enrolls as a
23 late enrollee or special enrollee, any period before such late or special enrollment

1 is not a waiting period. If an individual seeks coverage in the individual market, a
2 waiting period begins on the date the individual submits a substantially complete
3 application for coverage and ends on:

- 4 1. If the application results in coverage, the date coverage begins; or
- 5 2. If the application does not result in coverage, the date on which the
6 application is denied by the insurer or the date on which the offer of
7 coverage lapses.

- 8 (7) (a) 1. Except as otherwise provided under subsection (3) of this section, for
9 purposes of applying subsection (2)(c) of this section, a group health plan,
10 and a health insurance insurer offering group health insurance coverage,
11 shall count a period of creditable coverage without regard to the specific
12 benefits covered during the period.
- 13 2. A group health plan, or a health insurance insurer offering group health
14 insurance coverage, may elect to apply subsection (2)(c) of this section
15 based on coverage of benefits within each of several classes or categories
16 of benefits specified in federal regulations. This election shall be made on
17 a uniform basis for all participants and beneficiaries. Under this election, a
18 group health plan or insurer shall count a period of creditable coverage
19 with respect to any class or category of benefits if any level of benefits is
20 covered within this class or category.
 - 21 3. In the case of an election with respect to a group health plan under
22 subparagraph 2. of this paragraph, whether or not health insurance
23 coverage is provided in connection with the plan, the plan shall:

1 a. Prominently state in any disclosure statements concerning the plan,
2 and state to each enrollee at the time of enrollment under the plan,
3 that the plan has made this election; and

4 b. Include in these statements a description of the effect of this
5 election.

6 (b) Periods of creditable coverage with respect to an individual shall be established
7 through presentation of certifications described in subsection (9) of this section or
8 in such other manner as may be specified in administrative regulations.

9 (8) (a) Subject to paragraph (e) of this subsection, a group health plan, and a health
10 insurance insurer offering group health insurance coverage, may not impose any
11 pre-existing condition exclusion on a child who, within thirty (30) days after birth,
12 is covered under any creditable coverage. If a child is enrolled in a group health
13 plan or other creditable coverage within thirty (30) days after birth and
14 subsequently enrolls in another group health plan without a significant break in
15 coverage, the other group health plan may not impose any pre-existing condition
16 exclusion on the child.

17 (b) Subject to paragraph (e) of this subsection, a group health plan, and a health
18 insurance insurer offering group health insurance coverage, may not impose any
19 pre-existing condition exclusion on a child who is adopted or placed for adoption
20 before attaining eighteen (18) years of age and who, within thirty (30) days after
21 the adoption or placement for adoption, is covered under any creditable coverage.
22 If a child is enrolled in a group health plan or other creditable coverage within
23 thirty (30) days after adoption or placement for adoption and subsequently enrolls

1 in another group health plan without a significant break in coverage, the other
2 group health plan may not impose any pre-existing condition exclusion on the
3 child. This shall not apply to coverage before the date of the adoption or
4 placement for adoption.

5 (c) A group health plan may not impose any pre-existing condition exclusion relating
6 to pregnancy.

7 (d) A group health plan may not impose a pre-existing condition exclusion relating to
8 a condition based solely on genetic information. If an individual is diagnosed with
9 a condition, even if the condition relates to genetic information, the insurer may
10 impose a pre-existing condition exclusion with respect to the condition, subject to
11 other requirements of this section.

12 (e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual
13 after the end of the first sixty-three (63) day period during all of which the
14 individual was not covered under any creditable coverage.

15 (9) **Notwithstanding subsection (8) (a), (b) and (e), a health insurance issuer offering**
16 **group health insurance shall not impose any pre-existing condition exclusion on a**
17 **covered person who is under age nineteen (19).**

18 (a) 1. A group health plan, and a health insurance insurer offering group health
19 insurance coverage, shall provide a certificate of creditable coverage as
20 described in subparagraph 2. of this subsection. A certificate of creditable
21 coverage shall be provided, without charge, for participants or dependents
22 who are or were covered under a group health plan upon the occurrence of
23 any of the following events:

- 1 a. At the time an individual ceases to be covered under a health
- 2 benefit plan or otherwise becomes eligible under a COBRA
- 3 continuation provision;
- 4 b. In the case of an individual becoming covered under a COBRA
- 5 continuation provision, at the time the individual ceases to be
- 6 covered under the COBRA continuation provision; and
- 7 c. On request on behalf of an individual made not later than twenty-
- 8 four (24) months after the date of cessation of the coverage
- 9 described in subdivision a. or b. of this subparagraph, whichever is
- 10 later.

11 The certificate of creditable coverage as described under subdivision a. of
12 this subparagraph may be provided, to the extent practicable, at a time
13 consistent with notices required under any applicable COBRA
14 continuation provision.

- 15 2. The certification described in this subparagraph is a written certification
- 16 of:
 - 17 a. The period of creditable coverage of the individual under the
 - 18 health benefit plan and the coverage, if any, under the COBRA
 - 19 continuation provision; and
 - 20 b. The waiting period, if any, and affiliation period, if applicable,
 - 21 imposed with respect to the individual for any coverage under the plan.
- 22 3. To the extent that medical care under a group health plan consists of group
- 23 health insurance coverage, the plan is deemed to have satisfied the

1 certification requirement under this paragraph if the health insurance
2 insurer offering the coverage provides for the certification in accordance
3 with this paragraph.

4 (b) In the case of an election described in subsection (7)(a)2. of this section by a
5 group health plan or health insurance insurer, if the plan or insurer enrolls an
6 individual for coverage under the plan and the individual provides a certification
7 of coverage of the individual under paragraph (a) of this subsection:

- 8 1. Upon request of that plan or insurer, the entity that issued the certification
9 provided by the individual shall promptly disclose to the requesting plan
10 or insurer information on coverage of classes and categories of health
11 benefits available under the entity's plan or coverage; and
- 12 2. The entity may charge the requesting plan or insurer for the reasonable
13 cost of disclosing this information.

14 (10) (a) A group health plan, and a health insurance insurer offering group health
15 insurance coverage in connection with a group health plan, shall permit an
16 employee who is eligible but not enrolled for coverage under the terms of the
17 plan, or a dependent of that employee if the dependent is eligible but not enrolled
18 for coverage under these terms, to enroll for coverage under the terms of the plan
19 if each of the following conditions is met:

- 20 1. The employee or dependent was covered under a group health plan or had
21 health insurance coverage at the time coverage was previously offered to
22 the employee or dependent;

- 1 2. The employee stated in writing at that time that coverage under a group
2 health plan or health insurance coverage was the reason for declining
3 enrollment, but only if the plan sponsor or insurer, if applicable, required
4 that statement at that time and provided the employee with notice of the
5 requirement, and the consequences of the requirement, at that time;
- 6 3. The employee's or dependent's coverage described in subparagraph 1. of
7 this paragraph:
- 8 a. Was under a COBRA continuation provision and the coverage
9 under that provision was exhausted; or
- 10 b. Was not under such a provision and either the coverage was
11 terminated as a result of loss of eligibility for the coverage,
12 including as a result of legal separation, divorce, cessation of
13 dependent status, such as obtaining the maximum age to be eligible
14 as a dependent child, death of the employee, termination of
15 employment, reduction in the number of hours of employment,
16 employer contributions toward the coverage were terminated, a
17 situation in which an individual incurs a claim that would meet or
18 exceed a lifetime limit on all benefits, or a situation in which a plan
19 no longer offers any benefits to the class of similarly situated
20 individuals that includes the individual; or
- 21 c. Was offered through a health maintenance organization or other
22 arrangement in the group market that does not provide benefits to
23 individuals who no longer reside, live, or work in a service area

1 and, loss of coverage in the group market occurred because an
2 individual no longer resides, lives, or works in the service area,
3 whether or not within the choice of the individual, and no other
4 benefit package is available to the individual; and

5 4. An insurer shall allow an employee and dependent a period of at least
6 thirty (30) days after an event described in this paragraph has occurred to
7 request enrollment for the employee or the employee's dependent.
8 Coverage shall begin no later than the first day of the first calendar month
9 beginning after the date the insurer receives the request for special
10 enrollment.

11 (b) A dependent of a current employee, including the employee's spouse, and the
12 employee each are eligible for enrollment in the group health plan subject to plan
13 eligibility rules conditioning dependent enrollment on enrollment of the employee
14 if the requirements of paragraph (a) of this subsection are satisfied.

15 (c) 1. If:
16 a. A group health plan makes coverage available with respect to a
17 dependent of an individual;
18 b. The individual is a participant under the plan, or has met any
19 waiting period applicable to becoming a participant under the plan
20 and is eligible to be enrolled under the plan but for a failure to
21 enroll during a previous enrollment period; and
22 c. A person becomes such a dependent of the individual through
23 marriage, birth, or adoption or placement for adoption;

1 the group health plan shall provide for a dependent special enrollment
2 period described in subparagraph 2. of this paragraph during which the
3 person or, if not otherwise enrolled, the individual, may be enrolled under
4 the plan as a dependent of the individual, and in the case of the birth or
5 adoption of a child, the spouse of the individual may be enrolled as a
6 dependent of the individual if the spouse is otherwise eligible for
7 coverage.

8 2. A dependent special enrollment period under this subparagraph shall be a
9 period of at least thirty (30) days and shall begin on the later of:

- 10 a. The date dependent coverage is made available; or
11 b. The date of the marriage, birth, or adoption or placement for
12 adoption, as the case may be, described in subparagraph 1.c. of this
13 paragraph.

14 3. If an individual seeks to enroll a dependent during the first thirty (30) days
15 of the dependent special enrollment period, the coverage of the dependent
16 shall become effective:

- 17 a. In the case of marriage, not later than the first day of the first
18 month beginning after the date the completed request for
19 enrollment is received;
20 b. In the case of a dependent's birth, as of the date of the birth; or
21 c. In the case of a dependent's adoption or placement for adoption,
22 the date of the adoption or placement for adoption.

1 (d) At or before the time an employee is initially offered the opportunity to enroll in a
2 group health plan, the employer shall provide the employee with a notice of
3 special enrollment rights.

4 (11) (a) In the case of a group health plan that offers medical care through health
5 insurance coverage offered by a health maintenance organization, the plan may
6 provide for an affiliation period with respect to coverage through the organization
7 only if:

- 8 1. No pre-existing condition exclusion is imposed with respect to coverage
9 through the organization;
- 10 2. The period is applied uniformly without regard to any health status-related
11 factors; and
- 12 3. The period does not exceed two (2) months, or three (3) months in the
13 case of a late enrollee.

14 (b) 1. For purposes of this section, the term "affiliation period" means a period
15 which, under the terms of the health insurance coverage offered by the
16 health maintenance organization, must expire before the health insurance
17 coverage becomes effective. The organization is not required to provide
18 health care services or benefits during this period and no premium shall be
19 charged to the participant or beneficiary for any coverage during the
20 period.

21 2. This period shall begin on the enrollment date.

22 3. An affiliation period under a plan shall run concurrently with any waiting
23 period under the plan.

1 (c) A health maintenance organization described in paragraph (a) of this subsection
2 may use alternative methods other than those described in that paragraph to
3 address adverse selection as approved by the commissioner.

4 Section 20. KRS 304.17A-505 is amended to read as follows:

5 An insurer shall disclose in writing to a covered person and an insured or enrollee, in a manner
6 consistent with the provisions of KRS 304.14-420 to 304.14-450, the terms and conditions of its
7 health benefit plan and shall promptly provide the covered person and enrollee with written
8 notification of any change in the terms and conditions prior to the effective date of the change.

9 The insurer shall provide the required information at the time of enrollment and upon request
10 thereafter.

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

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

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

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

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

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

20 (f) Changes in covered services or benefits, including any addition, reduction, or
21 elimination of specific services or benefits;

22 (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 **an adverse benefit determination** [~~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; **and**
 4. **Contact information for the department where the covered person may obtain assistance with the internal appeal and 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.
- (2) The insurer shall file the information required under this section with the department.
- Section 21. KRS 304.17A-600 is amended to read as follows:

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

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

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

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

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

14 (2) ~~(3)~~ "Concurrent review" means utilization review conducted during a covered person's
15 course of treatment or hospital stay;

16 (3) ~~(4)~~ "Coverage Denial" means an insurer's determination that a service, treatment, drug,
17 or device is specifically limited or excluded under the covered person's health benefit
18 plan.

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

20 (6) ~~(5)~~ "External review" means a review that is conducted by an independent review entity
21 which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and
22 304.17A-627;

1 (7) [~~(6)~~] "Health benefit plan" means the document evidencing and setting forth the terms and
2 conditions of coverage of any hospital or medical expense policy or certificate; nonprofit
3 hospital, medical-surgical, and health service corporation contract or certificate; provider
4 sponsored integrated health delivery network policy or certificate; a self-insured policy or
5 certificate or a policy or certificate provided by a multiple employer welfare arrangement,
6 to the extent permitted by ERISA; health maintenance organization contract; or any
7 health benefit plan that affects the rights of a Kentucky insured and bears a reasonable
8 relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not
9 include policies covering only accident, credit, dental, disability income, fixed indemnity
10 medical expense reimbursement policy, long-term care, Medicare supplement, specified
11 disease, vision care, coverage issued as a supplement to liability insurance, insurance
12 arising out of a workers' compensation or similar law, automobile medical-payment
13 insurance, insurance under which benefits are payable with or without regard to fault and
14 that is statutorily required to be contained in any liability insurance policy or equivalent
15 self-insurance, student health insurance offered by a Kentucky-licensed insurer under
16 written contract with a university or college whose students it proposes to insure, medical
17 expense reimbursement policies specifically designed to fill gaps in primary coverage,
18 coinsurance, or deductibles and provided under a separate policy, certificate, or contract,
19 or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United
20 States Code; or limited health service benefit plans; and for purposes of KRS 304.17A-
21 600 to 304.17A-633 includes short-term coverage policies;

1 (8) [(7)] "Independent review entity" means an individual or organization certified by the
2 department to perform external reviews under KRS 304.17A-623, 304.17A-625, and
3 304.17A-627;

4 (9) [(8)] "Insurer" means any of the following entities authorized to issue health benefit plans as
5 defined in subsection (6) of this section: an insurance company, health maintenance
6 organization; self-insurer or multiple employer welfare arrangement not exempt from
7 state regulation by ERISA; provider-sponsored integrated health delivery network; self-
8 insured employer-organized association; nonprofit hospital, medical-surgical, or health
9 service corporation; or any other entity authorized to transact health insurance business in
10 Kentucky;

11 (10) [(9)] "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617,
12 established and maintained by the insurer, its designee, or agent whereby the covered
13 person, an authorized person, or a provider may contest an adverse ***benefit*** determination
14 rendered by the insurer, its designee, or private review agent;

15 (11) [(10)] "Nationally recognized accreditation organization" means a private nonprofit entity
16 that sets national utilization review and internal appeal standards and conducts review of
17 insurers, agents, or independent review entities for the purpose of accreditation or
18 certification. Nationally recognized accreditation organizations shall include the National
19 Committee for Quality Assurance (NCQA), the American Accreditation Health Care
20 Commission (URAC), the Joint Commission on Accreditation of Healthcare
21 Organizations (JCAHO), or any other organization identified by the department;

22 (12) [(11)] "Private review agent" or "agent" means a person or entity performing utilization
23 review that is either affiliated with, under contract with, or acting on behalf of any insurer

1 or other person providing or administering health benefits to citizens of this
2 Commonwealth. "Private review agent" or "agent" does not include an independent
3 review entity which performs external review of adverse determinations;

4 (13)[(12)] "Prospective review" means utilization review that is conducted prior to a hospital
5 admission or a course of treatment;

6 (14)[(13)] "Provider" shall have the same meaning as set forth in KRS 304.17A-005;

7 (15)[(14)] "Qualified personnel" means licensed physician, registered nurse, licensed practical
8 nurse, medical records technician, or other licensed medical personnel who through
9 training and experience shall render consistent decisions based on the review criteria;

10 (16)[(15)] "Registration" means an authorization issued by the department to an insurer or a
11 private review agent to conduct utilization review;

12 (17)[(16)] "Retrospective review" means utilization review that is conducted after health care
13 services have been provided to a covered person. "Retrospective review" does not include
14 the review of a claim that is limited to an evaluation of reimbursement levels, or
15 adjudication of payment;

16 (18)[(17)] (a) "Urgent care" means health care or treatment with respect to which the
17 application of the time periods for making nonurgent determination:

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

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

2 (19)~~[(18)]~~ "Utilization review" means a review of the medical necessity and appropriateness of

3 hospital resources and medical services given or proposed to be given to a covered person

4 for purposes of determining the availability of payment. Areas of review include

5 concurrent, prospective, and retrospective review; and

6 (20)~~[(19)]~~ "Utilization review plan" means a description of the procedures governing utilization

7 review activities performed by an insurer or a private review agent.

8 Section 22. KRS 304.17A-605 is amended to read as follows:

9 (1) KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A-609, 304.17A-611,

10 304.17A-613, and 304.17A-615 set forth the requirements and procedures regarding

11 utilization review and shall apply to:

12 (a) Any insurer or its private review agent that provides or performs utilization review in
13 connection with a health benefit plan or a limited health service benefit plan; and

14 (b) Any private review agent that performs utilization review functions on behalf of any
15 person providing or administering health benefit plans or limited health service
16 benefit plans.

17 (2) Where an insurer or its agent provides or performs utilization review, and in all instances
18 where internal appeals as set forth in KRS 304.17A-617 are involved, the insurer or its agent
19 shall be responsible for:

20 (a) Monitoring all utilization reviews and internal appeals carried out by or on behalf of
21 the insurer;

22 (b) Ensuring that all requirements of KRS 304.17A-600 to 304.17A-633 are met;

23 (c) Ensuring that all administrative regulations promulgated in accordance with KRS
24 304.17A-609, 304.17A-613, and 304.17A-629 are complied with; ~~and~~

1 (d) Ensuring that appropriate personnel have operational responsibility for the
2 performance of the insurer's utilization review plan; and

3 (e) Ensuring that all utilization reviews and internal appeals are adjudicated in a
4 manner designed to ensure the independence and impartiality of the persons
5 involved in making the decision.

6 (3) A private review agent that operates solely under contract with the federal government for
7 utilization review or patients eligible for hospital services under Title XVIII of the Social
8 Security Act shall not be subject to the registration requirements set forth in KRS 304.17A-
9 607, 304.17A-609, and 304.17A-613.

10 Section 23. KRS 304.17A-607 is amended to read as follows:

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

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

17 (b) Ensure that only licensed physicians shall:

- 18 1. Make a utilization review decision to deny, reduce, limit, or terminate a
19 health care benefit or to deny, or reduce payment for a health care service
20 because that service is not medically necessary, experimental, or
21 investigational except in the case of a health care service rendered by a
22 chiropractor or optometrist where the denial shall be made respectively by a
23 chiropractor or optometrist duly licensed in Kentucky; and
24 2. Supervise qualified personnel conducting case reviews;

- 1 (c) Have available the services of sufficient numbers of practicing physicians in
2 appropriate specialty areas to assure the adequate review of medical and surgical
3 specialty and subspecialty cases;
- 4 (d) Not disclose or publish individual medical records or any other confidential medical
5 information in the performance of utilization review activities except as provided in
6 the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264
7 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative
8 regulations;
- 9 (e) Provide a toll free telephone line for covered persons, authorized persons, and
10 providers to contact the insurer or private review agent and be accessible to covered
11 persons, authorized persons, and providers for forty (40) hours a week during normal
12 business hours in this state;
- 13 (f) Where an insurer, its agent, or private review agent provides or performs utilization
14 review, be available to conduct utilization review during normal business hours and
15 extended hours in this state on Monday and Friday through 6:00 p.m., including
16 federal holidays;
- 17 (g) Provide decisions to covered persons, authorized persons, and all providers on
18 appeals of adverse determinations and coverage denials of the insurer or private
19 review agent, in accordance with this section and administrative regulations
20 promulgated in accordance with KRS 304.17A-609;
- 21 (h) Except for retrospective review of an emergency admission where the covered person
22 remains hospitalized at the time the review request is made, which shall be
23 considered a concurrent review, provide a utilization review decision relating to
24 urgent and nonurgent care in accordance with 29 C.F.R. Part 2560, including the
25 timeframes and written notice of the decision. A written notice in electronic format,

1 including e-mail or facsimile, may suffice for this purpose where the covered person,
2 authorized person, or provider has agreed in advance in writing to receive such
3 notices electronically and shall include the required elements of subsection (j) of this
4 section;

5 (i) Provide a utilization review decision within twenty-four (24) hours of receipt of a
6 request for review of a covered person's continued course of treatment or continued
7 hospital stay and prior to the time when a previous authorization for hospital care will
8 expire;

9 (j) Provide written notice of review decisions to the covered person, authorized person,
10 and providers. An insurer or agent that denies coverage or reduces payment for a
11 treatment, procedure, drug that requires prior approval, or device shall include in the
12 written notice:

13 1. Specific information sufficient to identify the benefit being denied;

14 2. An explanation [A statement] of the specific medical and scientific reasons
15 for denial or reduction of payment or identifying that provision of the
16 schedule of benefits or exclusions that demonstrates that coverage is not
17 available;

18 3. [2.] The state of licensure, medical license number, and the title of the reviewer
19 making the decision;

20 4. [3.] Except for retrospective review, a description of alternative benefits, services,
21 or supplies covered by the health benefit plan, if any; and

22 5. [4.] Instructions for initiating or complying with the insurer's internal appeal
23 procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether
24 the appeal shall be in writing, and any specific filing procedures, including

1 any applicable time limitations or schedules, and the position and phone
2 number of a contact person who can provide additional information;

3 (k) Afford participating physicians an opportunity to review and comment on all medical
4 and surgical and emergency room protocols, respectively, of the insurer and afford
5 other participating providers an opportunity to review and comment on all of the
6 insurer's protocols that are within the provider's legally authorized scope of practice;
7 and

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

12 (2) The insurer's failure to make a determination and provide written notice within the time
13 frames set forth in this section shall be deemed to be an adverse benefit determination by the
14 insurer for the purpose of initiating an internal appeal as set forth in KRS 304.17A-617. This
15 provision shall not apply where the failure to make the determination or provide the notice
16 results from circumstances which are documented to be beyond the insurer's control.

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

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

23 Section 24. KRS 304.17A-617 is amended to read as follows:

- 1 (1) Every insurer shall have an internal appeal process to be utilized by the insurer or its
2 designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to
3 covered persons in accordance with KRS 304.17A-505(1)(g). An insurer shall disclose the
4 availability of the internal process to the covered person in the insured's timely notice of an
5 adverse **benefit** determination or notice of a coverage denial which meets the requirements
6 set forth in KRS 304.17A-607(1)(j). **An insurer shall be required to provide continued**
7 **coverage of an on-going course of treatment until a decision is rendered in accordance**
8 **with subsection (2) of this section.** [For purposes of this section, "coverage denial" means
9 an insurer's determination that a service, treatment, drug, or device is specifically limited or
10 excluded under the covered person's health benefit plan. Where a coverage denial is involved,
11 in addition to stating the reason for the coverage denial, the required notice shall contain
12 instructions for filing a request for internal appeal.]
- 13 (2) The internal appeals process may be initiated by the covered person, an authorized person, or
14 a provider acting on behalf of the covered person. The internal appeals process shall include
15 adequate and reasonable procedures for **full and fair** review and resolution of appeals
16 concerning adverse determinations made under utilization review and of coverage denials,
17 including procedures for reviewing appeals from covered persons whose medical conditions
18 require expedited review. At a minimum, these procedures shall include the following:
- 19 (a) Insurers or their designees shall provide decisions to covered persons, authorized
20 persons, and providers on internal appeals of adverse **benefit** determinations or
21 coverage denials within thirty (30) days of receipt of the request for internal appeal;
- 22 (b) Insurers or their designees shall render a decision not later than **twenty-four (24)**
23 **hours** [~~three (3) business days~~] after receipt of the request for an expedited appeal of
24 either an adverse **benefit** determination or a coverage denial. An expedited appeal is

1 deemed necessary when a covered person is hospitalized or, in the opinion of the
2 treating provider, review under a standard time frame could, in the absence of
3 immediate medical attention, result in any of the following:

- 4 1. Placing the health of the covered person or, with respect to a pregnant
5 woman, the health of the covered person or the unborn child in serious
6 jeopardy;
- 7 2. Serious impairment to bodily functions; [ø€]
- 8 3. Serious dysfunction of a bodily organ or part; or
- 9 4. Severe pain that is not manageable without the care or treatment that is the
10 subject of the adverse benefit determination;

- 11 (c) Internal appeal of an adverse determination shall only be conducted by a licensed
12 physician who did not participate in the initial review and denial. However, in the
13 case of a review involving a medical or surgical specialty or subspecialty, the insurer
14 or agent shall, upon request by a covered person, authorized person, or provider,
15 utilize a board eligible or certified physician in the appropriate specialty or
16 subspecialty area to conduct the internal appeal;
- 17 (d) Those portions of the medical record that are relevant to the internal appeal, if
18 authorized by the covered person and in accordance with state or federal law, shall be
19 considered and providers given the opportunity to present additional information; and
- 20 (e) In addition to any previous notice required under KRS 304.17A-607(1)(j), and to
21 facilitate expeditious handling of a request for external review of an adverse
22 determination or a coverage denial, an insurer or agent that denies, limits, reduces, or
23 terminates coverage for a treatment, procedure, drug, or device for a covered person
24 shall provide the covered person, authorized person, or provider acting on behalf of
25 the covered person with an internal appeal determination letter that shall include:

1 1. Specific information sufficient to identify the benefit being denied;

2 2. An explanation [A statement] of the specific medical and scientific reasons
3 for denying coverage or identifying that provision of the schedule of benefits
4 or exclusions that demonstrates that coverage is not available;

5 3. [2.] The state of licensure, medical license number, and the title of the person
6 making the decision;

7 4. [3.] Except for retrospective review, a description of alternative benefits, services,
8 or supplies covered by the health benefit plan, if any; and

9 5. [4.] Instructions for initiating an external review of an adverse benefit
10 determination, or filing a request for review with the department if a coverage
11 denial is upheld by the insurer on internal appeal.

12 (3) The department shall establish and maintain a system for receiving and reviewing requests
13 for review of coverage denials from covered persons, authorized persons, and providers. For
14 purposes of this subsection, "coverage denials" shall not include an adverse determination as
15 defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

16 (a) On receipt of a written request for review of a coverage denial from a covered person,
17 authorized person, or provider, the department shall notify the insurer which issued
18 the denial of the request for review and shall call for the insurer to respond to the
19 department regarding the request for review within ten (10) business days of receipt
20 of notice to the insurer.

21 (b) Within ten (10) business days of receiving the notice of the request for review from
22 the department, the insurer shall provide to the department the following information:

23 1. Confirmation as to whether the person who received or sought the health
24 service for which coverage was denied was a covered person under a health

1 benefit plan issued by the insurer on the date the service was sought or
2 denied;

3 2. Confirmation as to whether the covered person, authorized person, or
4 provider has exhausted his or her rights under the insurer's appeal process
5 under this section; and

6 3. The reason for the coverage denial, including the specific limitation or
7 exclusion of the health benefit plan demonstrating that coverage is not
8 available.

9 (c) In addition to the information described in paragraph (b) of this subsection, the
10 insurer and the covered person, authorized person, or provider shall provide to the
11 department any information requested by the department that is germane to its
12 review.

13 (d) On the receipt of the information described in paragraphs (b) and (c) of this
14 subsection, unless the department is not able to do so because making a determination
15 requires resolution of a medical issue, it shall determine whether the service,
16 treatment, drug, or device is specifically limited or excluded under the terms of the
17 covered person's health benefit plan. If the department determines that the treatment,
18 service, drug, or device is not specifically limited or excluded, it shall so notify the
19 insurer, and the insurer shall either cover the service, or afford the covered person an
20 opportunity for external review under KRS 304.17A-621, 304.17A-623, and
21 304.17A-625, where the conditions precedent to the review are present. If the
22 department notifies the insurer that the treatment, service, drug, or device is
23 specifically limited or excluded in the health benefit plan, the insurer is not required
24 to cover the service or afford the covered person an external review.

1 (e) An insurer shall be required to cover the treatment, service, drug, or device that was
2 denied or provide notification of the right to external review in accordance with
3 paragraph (d) of this subsection whether the covered person has disenrolled or
4 remains enrolled with the insurer.

5 (f) If the covered person has disenrolled with the insurer, the insurer shall only be
6 required to provide the treatment, service, drug, or device that was denied for a period
7 not to exceed thirty (30) days, or provide the covered person the opportunity for
8 external review.

9 Section 25. KRS 304.17A-619 is amended to read as follows:

10 (1) If the covered person, authorized person, or provider has new clinical information
11 regarding the covered person's internal appeal he or she shall provide that information to
12 the insurer prior to the initiation of the external review process. The insurer shall have
13 five (5) business days from the date of the receipt of the information to render a decision
14 based on the new information. If new information is provided in accordance with this
15 section, the one hundred and twenty (120) ~~sixty (60)~~ day time frame for commencing
16 an external review as set forth in KRS 304.17A-623(4), shall not begin to run, until the
17 insurer or its designee renders a decision regarding the new information.

18 (2) The insurer's failure to make a determination or provide a written notice within the time
19 frames set forth in KRS 304.17A-617 shall be deemed to be an adverse determination by
20 the insurer for the purpose of initiating an external review as set forth in KRS 304.17A-
21 623.

22 Section 26. KRS 304.17A-623 is amended to read as follows:

23 (1) Every insurer shall have an external review process to be utilized by the insurer or its
24 designee, consistent with this section and which shall be disclosed to covered persons in

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

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

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

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

14 (b) 1. The covered person has completed the insurer's internal appeal process; ~~;~~
15 ~~or~~

16 2. ***The*** [the] insurer has failed to make a timely determination or notification
17 as set forth in KRS 304.17A-619(2); ***or***

18 3. ***The covered person has applied for expedited external review at the***
19 ***same time as applying for an expedited internal appeal as set forth in subsection***
20 ***(10) of this section.***

21 The insurer and the covered person may however, jointly agree to waive the
22 internal appeal requirement;

- 1 (c) The covered person was enrolled in the health benefit plan on the date of service
2 or, if a prospective denial, the covered person was enrolled and eligible to receive
3 covered benefits under the health benefit plan on the date the proposed service
4 was requested; and
- 5 (d) **The adverse benefit determination was based on the insurer's requirements for**
6 **medical necessity, appropriateness, health care setting, level of care, or**
7 **effectiveness of a covered treatment** [The entire course of treatment or service
8 will cost the covered person at least one hundred dollars (\$100) if the covered
9 person had no insurance].
- 10 (4) The covered person, an authorized person, or a provider with consent of the covered
11 person shall submit a request for external review to the insurer within **one hundred**
12 **twenty (120)** [sixty (60)] days, except as set forth in KRS 304.17A-619(1), of receiving
13 notice that an adverse determination has been timely rendered under the insurer's internal
14 appeal process. As part of the request, the covered person shall provide to the insurer or
15 its designee written consent authorizing the independent review entity to obtain all
16 necessary medical records from both the insurer and any provider utilized for review
17 purposes regarding the decision to deny, limit, reduce or terminate coverage.
- 18 (5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars (\$25)
19 to be paid to the independent review entity and which may be waived if the independent
20 review entity determines that the fee creates a financial hardship on the covered person.
21 The fee shall be refunded if the independent review entity finds in favor of the covered
22 person.
- 23 (6) A covered person shall not be afforded an external review of an adverse determination if:

- 1 (a) The subject of the covered person's adverse determination has previously gone
2 through the external review process and the independent review entity found in
3 favor of the insurer; and
- 4 (b) No relevant new clinical information has been submitted to the insurer since the
5 independent review entity found in favor of the insurer.
- 6 (7) The department shall establish a system for each insurer to be assigned an independent
7 review entity for external reviews. The system established by the department shall be
8 prospective and shall require insurers to utilize independent review entities on a rotating
9 basis so that an insurer does not have the same independent review entity for two (2)
10 consecutive external reviews. The department shall contract with no less than two (2)
11 independent review entities.
- 12 (8) (a) If a dispute arises between an insurer and a covered person regarding the covered
13 person's right to an external review, the covered person may file a complaint with
14 the department. Within five (5) days of receipt of the complaint, the department
15 shall render a decision and may direct the insurer to submit the dispute to an
16 independent review entity for an external review if it finds:
- 17 1. The dispute involves denial of coverage based on medical necessity,
18 *appropriateness, health care setting, level of care, or effectiveness of a*
19 *covered treatment* ~~[or the service being experimental or investigational];~~
20 and
- 21 2. All of the requirements of subsection (3) of this section have been met.
- 22 (b) The complaint process established in this section shall be separate and distinct
23 from, and shall in no way limit other grievance or complaint processes available

1 to consumers under other provisions of the KRS or duly promulgated
2 administrative regulations. This complaint process shall not limit, alter, or
3 supplant the mechanisms for appealing coverage denials established in KRS
4 304.17A-617.

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

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

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

13 (b) Serious impairment to bodily functions; [øø]

14 (c) Serious dysfunction of a bodily organ or part; or

15 (d) For a denial of coverage based upon a determination that a service is
16 experimental or investigational, the treatment being significantly less effective if
17 not promptly initiated.

18 (11) If the conditions of subsection 10 of this section are met, a covered person or a covered
19 person's authorized representative may make a request for an expedited external
20 review at the same time the covered person or covered person's authorized
21 representative makes a request for an expedited internal appeal.

22 (12) [(44)] Requests for expedited external review, shall be forwarded by the insurer to the
23 independent review entity within twenty-four (24) hours of receipt by the insurer.

1 (13) [~~(12)~~] For expedited external review, a determination shall be made by the independent
2 review entity within twenty-four (24) hours from the receipt of all information required
3 from the insurer. An extension of up to twenty-four (24) hours may be allowed if the
4 covered person and the insurer or its designee agree. The insurer or its designee shall
5 provide notice to the independent review entity and to the covered person, by same-day
6 communication, that the adverse determination has been assigned to an independent
7 review entity for expedited review.

8 (14) [~~(13)~~] External reviews which are not expedited shall be conducted by the independent
9 review entity and a determination made within twenty-one (21) calendar days from the
10 receipt of all information required from the insurer. An extension of up to fourteen (14)
11 calendar days may be allowed if the covered person and the insurer are in agreement.

12 Section 27. KRS 304.17A-627 is amended to read as follows:

- 13 (1) To be certified as an independent review entity under this chapter, an organization shall
14 submit to the department an application on a form required by the department. The
15 application shall include the following:
- 16 (a) The name of each stockholder or owner of more than five percent (5%) of any stock
17 or options for an applicant;
 - 18 (b) The name of any holder of bonds or notes of the applicant that exceeds one hundred
19 thousand dollars (\$100,000);
 - 20 (c) The name and type of business of each corporation or other organization that the
21 applicant controls or with which it is affiliated and the nature and extent of the
22 affiliation or control;
 - 23 (d) The name and a biographical sketch of each director, officer, and executive of the
24 applicant and any entity listed under paragraph (c) of this subsection and a

1 description of any relationship the named individual has with an insurer as defined in
2 KRS 304.17A-600 or a provider of health care services;

3 (e) The percentage of the applicant's revenues that are anticipated to be derived from
4 independent reviews;

5 (f) A description of the minimum qualifications employed by the independent review
6 entity to select health care professionals to perform external review, their areas of
7 expertise, and the medical credentials of the health care professionals currently
8 available to perform external reviews; ~~and~~

9 (g) The procedures to be used by the independent review entity in making review
10 determinations; ***and***

11 **(h) Proof of accreditation by a nationally recognized private accrediting organization.**

12 (2) If at any time there is a material change in the information included in the application,
13 provided for in subsection (1) of this section, the independent review entity shall submit
14 updated information to the department.

15 (3) An independent review entity shall not be a subsidiary of, or in any way affiliated with, or
16 owned, or controlled by:

17 **(a) An ~~an~~ insurer;**

18 **(b) A group health plan;**

19 **(c) A sponsor of a group health plan;** ~~[or]~~

20 **(d) A ~~a~~ trade ~~or professional~~ association of *plans or insurers; or***

21 **(e) A trade association of health care providers.** ~~[payers]~~

22 (4) An independent review entity shall not be a subsidiary of, or in any way affiliated with, or
23 owned, or controlled by a trade or professional association of providers.

24 (5) Health care professionals who are acting as reviewers for the independent review entity shall
25 hold in good standing a nonrestricted license in a state of the United States. **A reviewers shall not**

1 have a history of disciplinary actions or sanctions, including the loss of staff privileges or
2 participation restrictions, that have been taken or are pending by any hospital, governmental
3 agency or unit, or regulatory body that raise a substantial question as to the reviewer's physical,
4 mental or professional competence or moral character.

5 (6) Health care professionals who are acting as reviewers for the independent review entity shall
6 hold a current certification by a recognized American medical specialty board or other
7 recognized health care professional boards in the area appropriate to the subject of the
8 review, be a specialist in the treatment of the covered person's medical condition under
9 review, and have actual clinical experience in that medical condition.

- 1 (7) The independent review entity shall have a quality assurance mechanism to ensure the
2 timeliness and quality of the review, the qualifications and independence of the physician
3 reviewer, and the confidentiality of medical records and review material.
- 4 (8) Neither the independent review entity nor any reviewers of the entity, shall have any
5 material, professional, familial, or financial conflict of interest with any of the following:
- 6 (a) The insurer involved in the review;
 - 7 (b) Any officer, director, or management employee of the insurer;
 - 8 (c) The provider proposing the service or treatment or any associated independent
9 practice association;
 - 10 (d) The institution at which the service or treatment would be provided;
 - 11 (e) The development or manufacture of the principal drug, device, procedure, or other
12 therapy proposed for the covered person whose treatment is under review; or
 - 13 (f) The covered person.
- 14 (9) As used in this section, "conflict of interest" shall not be interpreted to include:
- 15 (a) A contract under which an academic medical center or other similar medical center
16 provides health care services to covered persons, except for academic medical centers
17 that may provide the service under review;
 - 18 (b) Provider affiliations which are limited to staff privileges; or
 - 19 (c) A specialist reviewer's relationship with an insurer as a contracting health care
20 provider, except for a specialist reviewer proposing to provide the service under
21 review.
- 22 (10) On an annual basis, the independent review entity shall report to the department the
23 following information:
- 24 (a) The number of independent review decisions in favor of covered persons;
 - 25 (b) The number of independent review decisions in favor of insurers;

- 1 (c) The average turnaround time for an independent review decision;
- 2 (d) The number of cases in which the independent review entity did not reach a decision
- 3 in the time specified in statute or administrative regulation; and
- 4 (e) The reasons for any delay.

5 Section 28. KRS 304.17A-629 is amended to read as follows:

6 The commissioner shall promulgate administrative regulations to implement the provisions of
7 KRS 304.17A-600 to 304.17A-633 [~~304.17A-621, 304.17A-623, 304.17A-625, 304.17A-627,~~
8 ~~304.17A-629, and 304.17A-631~~].

DRAFT