

304.17A-846 Providing of requested information on insureds by group health benefit plan insurers -- Confidentiality -- Additional information to be provided to large groups.

(1) Any insurer issuing or delivering group health benefit plans in the Commonwealth shall provide to an employer-organized association health benefit plan, within thirty (30) calendar days after a written request, the information relating to its health benefit plan that has been requested, including but not limited to the following information for the previous three (3) years or for the entire period of coverage, whichever is shorter:

- (a) Aggregate claims experience by month, including claims experience for pharmacy benefits;
- (b) Total premiums paid by month;
- (c) Total number of insureds on a monthly basis by coverage tier; and
- (d) Sufficient detailed claims information to permit the employer-organized association to verify eligibility and participation of the groups and individuals participating in the employer-organized association program.

The department shall, by July 15, 2005, promulgate administrative regulations to implement the provisions of this section and define the extent that individual information shall be provided.

(2) This section shall not require the insurer to disclose any nonpublic personal health information without the written consent of the individual who is the subject of the information, as required by administrative regulations promulgated by the commissioner. However, nonpublic personal health information may be provided to the employer-organized association health benefit plan and large group health benefit plan with fifty-one (51) or more enrolled employees as a covered entity to cover entity transfer under the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. sec. 300gg et seq., provided that the health benefit plan certifies to the insurer that it has adopted HIPAA-required safeguards and will treat the nonpublic personal health information in accordance with HIPAA standards.

(3) Any insurer issuing or delivering group health benefit plans in the Commonwealth shall provide to a large group health benefit plan with fifty-one (51) or more enrolled employees, within thirty (30) calendar days after receipt of a written request, the following information relating to its health benefit plan:

- (a) Total premiums paid by month;
- (b) Total number of insureds on a monthly basis by coverage tier; and
- (c) Additional utilization data to help the employer measure costs in the following areas:
 - 1. Detailed prescription drug utilization information, including generic versus brand utilization;
 - 2. Number of office visits to primary care providers and specialists;
 - 3. Number of emergency room visits;

4. Number of inpatient and outpatient hospitalizations;
 5. Number of members utilizing deductible and out-of-pocket expenses by cost level; and
 6. A list of the most prevalent disease categories.
- (4) Insurers shall not be required to produce reports requested pursuant to subsection (3) of this section more than twice annually.

Effective: July 15, 2010

History: Amended 2010 Ky. Acts ch. 24, sec. 1272, effective July 15, 2010. -- Amended 2007 Ky. Acts ch. 87, sec. 1, effective June 26, 2007. -- Created 2005 Ky. Acts ch. 144, sec. 1, effective June 20, 2005.