

1 AN ACT relating to emergency air ambulance coverage.

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

3 ➔Section 1. KRS 304.17A-005 is amended to read as follows:

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

- 5 (1) "Association" means an entity, other than an employer-organized association, that
6 has been organized and is maintained in good faith for purposes other than that of
7 obtaining insurance for its members and that has a constitution and bylaws;
- 8 (2) "At the time of enrollment" means:
- 9 (a) At the time of application for an individual, an association that actively
10 markets to individual members, and an employer-organized association that
11 actively markets to individual members; and
- 12 (b) During the time of open enrollment or during an insured's initial or special
13 enrollment periods for group health insurance;
- 14 (3) **"Balance bill" or "balance billing" refers to a provider billing an insured for the**
15 **remaining balance of the amount a provider charges for a service less the**
16 **amount an insurer reimburses, and any applicable deductibles or cost sharing the**
17 **insured is required to pay;**
- 18 **(4)** "Base premium rate" means, for each class of business as to a rating period, the
19 lowest premium rate charged or that could have been charged under the rating
20 system for that class of business by the insurer to the individual or small group, or
21 employer as defined in KRS 304.17A-0954, with similar case characteristics for
22 health benefit plans with the same or similar coverage;
- 23 **(5)**~~(4)~~ "Basic health benefit plan" means any plan offered to an individual, a small
24 group, or employer-organized association that limits coverage to physician,
25 pharmacy, home health, preventive, emergency, and inpatient and outpatient
26 hospital services in accordance with the requirements of this subtitle. If vision or
27 eye services are offered, these services may be provided by an ophthalmologist or

1 optometrist. Chiropractic benefits may be offered by providers licensed pursuant to
2 KRS Chapter 312;

3 ~~(6)~~~~(5)~~ "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
4 91(d)(3);

5 ~~(7)~~~~(6)~~ "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

6 ~~(8)~~~~(7)~~ "COBRA" means any of the following:

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

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

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

12 ~~(9)~~~~(8)~~ (a) "Creditable coverage" means, with respect to an individual, coverage of
13 the individual under any of the following:

14 1. A group health plan;

15 2. Health insurance coverage;

16 3. Part A or Part B of Title XVIII of the Social Security Act;

17 4. Title XIX of the Social Security Act, other than coverage consisting
18 solely of benefits under section 1928;

19 5. Chapter 55 of Title 10, United States Code, including medical and dental
20 care for members and certain former members of the uniformed services,
21 and for their dependents; for purposes of Chapter 55 of Title 10, United
22 States Code, "uniformed services" means the Armed Forces and the
23 Commissioned Corps of the National Oceanic and Atmospheric
24 Administration and of the Public Health Service;

25 6. A medical care program of the Indian Health Service or of a tribal
26 organization;

27 7. A state health benefits risk pool;

- 1 8. A health plan offered under Chapter 89 of Title 5, United States Code,
2 such as the Federal Employees Health Benefit Program;
- 3 9. A public health plan as established or maintained by a state, the United
4 States government, a foreign country, or any political subdivision of a
5 state, the United States government, or a foreign country that provides
6 health coverage to individuals who are enrolled in the plan;
- 7 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
8 U.S.C. sec. 2504(e)); or
- 9 11. Title XXI of the Social Security Act, such as the State Children's Health
10 Insurance Program.
- 11 (b) This term does not include coverage consisting solely of coverage of excepted
12 benefits as defined in ~~subsection (14) of~~ this section;
- 13 (10)~~(9)~~ "Dependent" means any individual who is or may become eligible for
14 coverage under the terms of an individual or group health benefit plan because of a
15 relationship to a participant;
- 16 (11)~~(10)~~ "Employee benefit plan" means an employee welfare benefit plan or an
17 employee pension benefit plan or a plan which is both an employee welfare benefit
18 plan and an employee pension benefit plan as defined by ERISA;
- 19 (12)~~(11)~~ "Eligible individual" means an individual:
- 20 (a) For whom, as of the date on which the individual seeks coverage, the
21 aggregate of the periods of creditable coverage is eighteen (18) or more
22 months and whose most recent prior creditable coverage was under a group
23 health plan, governmental plan, or church plan. A period of creditable
24 coverage under this paragraph shall not be counted if, after that period, there
25 was a sixty-three (63) day period of time, excluding any waiting or affiliation
26 period, during all of which the individual was not covered under any
27 creditable coverage;

- 1 (b) Who is not eligible for coverage under a group health plan, Part A or Part B of
2 Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a
3 state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et
4 seq.) and does not have other health insurance coverage;
- 5 (c) With respect to whom the most recent coverage within the coverage period
6 described in paragraph (a) of this subsection was not terminated based on a
7 factor described in KRS 304.17A-240(2)(a), (b), and (c);
- 8 (d) If the individual had been offered the option of continuation coverage under a
9 COBRA continuation provision or under KRS 304.18-110, who elected the
10 coverage; and
- 11 (e) Who, if the individual elected the continuation coverage, has exhausted the
12 continuation coverage under the provision or program;

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

- 14 (a) Any entity that was qualified by the commissioner as an eligible association
15 prior to April 10, 1998, and that has actively marketed a health insurance
16 program to its members since September 8, 1996, and which is not insurer-
17 controlled;
- 18 (b) Any entity organized under KRS 247.240 to 247.370 that has actively
19 marketed health insurance to its members and that is not insurer-controlled; or
- 20 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-
21 91(d)(3), whose members consist principally of employers, and for which the
22 entity's health insurance decisions are made by a board or committee, the
23 majority of which are representatives of employer members of the entity who
24 obtain group health insurance coverage through the entity or through a trust or
25 other mechanism established by the entity, and whose health insurance
26 decisions are reflected in written minutes or other written documentation.

27 Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and

1 except as otherwise provided by the definition of "large group" ***as defined***
2 **in**~~contained in subsection (30) of~~ this section, an employer-organized association
3 shall not be treated as an association, small group, or large group under this subtitle,
4 provided that an employer-organized association that is a bona fide association as
5 defined in ~~subsection (5)~~ of this section shall be treated as a large group under this
6 subtitle;

7 **(14)**~~(13)~~ "Employer-organized association health insurance plan" means any health
8 insurance plan, policy, or contract issued to an employer-organized association, or
9 to a trust established by one (1) or more employer-organized associations, or
10 providing coverage solely for the employees, retired employees, directors and their
11 spouses and dependents of the members of one (1) or more employer-organized
12 associations;

13 **(15)**~~(14)~~ "Excepted benefits" means benefits under one (1) or more, or any combination
14 thereof, of the following:

- 15 (a) Coverage only for accident, including accidental death and dismemberment,
16 or disability income insurance, or any combination thereof;
- 17 (b) Coverage issued as a supplement to liability insurance;
- 18 (c) Liability insurance, including general liability insurance and automobile
19 liability insurance;
- 20 (d) Workers' compensation or similar insurance;
- 21 (e) Automobile medical payment insurance;
- 22 (f) Credit-only insurance;
- 23 (g) Coverage for on-site medical clinics;
- 24 (h) Other similar insurance coverage, specified in administrative regulations,
25 under which benefits for medical care are secondary or incidental to other
26 insurance benefits;
- 27 (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 ~~(16)~~[(15)] "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
15 1002(32);
- 16 ~~(17)~~[(16)] "Group health plan" means a plan, including a self-insured plan, of or
17 contributed to by an employer, including a self-employed person, or employee
18 organization, to provide health care directly or otherwise to the employees, former
19 employees, the employer, or others associated or formerly associated with the
20 employer in a business relationship, or their families;
- 21 ~~(18)~~[(17)] "Guaranteed acceptance program participating insurer" means an insurer that
22 is required to or has agreed to offer health benefit plans in the individual market to
23 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
24 304.17A-480;
- 25 ~~(19)~~[(18)] "Guaranteed acceptance program plan" means a health benefit plan in the
26 individual market issued by an insurer that provides health benefits to a guaranteed
27 acceptance program qualified individual and is eligible for assessment and refunds

1 under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
2 ~~(20)~~~~(19)~~ "Guaranteed acceptance program" means the Kentucky Guaranteed
3 Acceptance Program established and operated under KRS 304.17A-400 to
4 304.17A-480;

5 ~~(21)~~~~(20)~~ "Guaranteed acceptance program qualified individual" means an individual
6 who, on or before December 31, 2000:

- 7 (a) Is not an eligible individual;
- 8 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
9 spouse or a dependent of an individual who:
- 10 1. Waived coverage under KRS 304.17A-210(2); or
11 2. Did not elect family coverage that was available through the association
12 or group market;
- 13 (c) Within the previous three (3) years has been diagnosed with or treated for a
14 high-cost condition or has had benefits paid under a health benefit plan for a
15 high-cost condition, or is a high risk individual as defined by the underwriting
16 criteria applied by an insurer under the alternative underwriting mechanism
17 established in KRS 304.17A-430(3);
- 18 (d) Has been a resident of Kentucky for at least twelve (12) months immediately
19 preceding the effective date of the policy; and
- 20 (e) Has not had his or her most recent coverage under any health benefit plan
21 terminated or nonrenewed because of any of the following:
- 22 1. The individual failed to pay premiums or contributions in accordance
23 with the terms of the plan or the insurer had not received timely
24 premium payments;
- 25 2. The individual performed an act or practice that constitutes fraud or
26 made an intentional misrepresentation of material fact under the terms of
27 the coverage; or

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

3 ~~(22)~~~~(21)~~ "Guaranteed acceptance plan supporting insurer" means either an insurer, on
4 or before December 31, 2000, that is not a guaranteed acceptance plan participating
5 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
6 guaranteed acceptance plan supporting insurer shall not include an employer-
7 sponsored self-insured health benefit plan exempted by ERISA;

8 ~~(23)~~~~(22)~~ "Health benefit plan" means any hospital or medical expense policy or
9 certificate; nonprofit hospital, medical-surgical, and health service corporation
10 contract or certificate; provider sponsored integrated health delivery network; a self-
11 insured plan or a plan provided by a multiple employer welfare arrangement, to the
12 extent permitted by ERISA; health maintenance organization contract; or any health
13 benefit plan that affects the rights of a Kentucky insured and bears a reasonable
14 relation to Kentucky, whether delivered or issued for delivery in Kentucky, and
15 does not include policies covering only accident, credit, dental, disability income,
16 fixed indemnity medical expense reimbursement policy, long-term care, Medicare
17 supplement, specified disease, vision care, coverage issued as a supplement to
18 liability insurance, insurance arising out of a workers' compensation or similar law,
19 automobile medical-payment insurance, insurance under which benefits are payable
20 with or without regard to fault and that is statutorily required to be contained in any
21 liability insurance policy or equivalent self-insurance, short-term coverage, student
22 health insurance offered by a Kentucky-licensed insurer under written contract with
23 a university or college whose students it proposes to insure, medical expense
24 reimbursement policies specifically designed to fill gaps in primary coverage,
25 coinsurance, or deductibles and provided under a separate policy, certificate, or
26 contract, or coverage supplemental to the coverage provided under Chapter 55 of
27 Title 10, United States Code, or limited health service benefit plans, or direct

1 primary care agreements established under KRS 311.6201, 311.6202, 314.198, and
2 314.199;

3 ~~(24)~~~~(23)~~ "Health care provider" or "provider" means any facility or service required to
4 be licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to
5 KRS Chapter 315, or home medical equipment and services provider as defined
6 pursuant to KRS 309.402, and any of the following independent practicing
7 practitioners:

- 8 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;
- 9 (b) Chiropractors licensed under KRS Chapter 312;
- 10 (c) Dentists licensed under KRS Chapter 313;
- 11 (d) Optometrists licensed under KRS Chapter 320;
- 12 (e) Physician assistants regulated under KRS Chapter 311;
- 13 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and
- 14 (g) Other health care practitioners as determined by the department by
15 administrative regulations promulgated under KRS Chapter 13A;

16 ~~(25)~~~~(24)~~ (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
17 Program, means a covered condition in an individual policy as listed in
18 paragraph (c) of this subsection or as added by the commissioner in
19 accordance with KRS 304.17A-280, but only to the extent that the condition
20 exceeds the numerical score or rating established pursuant to uniform
21 underwriting standards prescribed by the commissioner under paragraph (b) of
22 this subsection that account for the severity of the condition and the cost
23 associated with treating that condition.

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

- 27 1. Codes in the most recent version of the "International Classification of

1 Diseases" that correspond to the medical conditions in paragraph (c) of
2 this subsection and the costs for administering treatment for the
3 conditions represented by those codes; and

4 2. The most recent version of the questionnaire incorporated in a national
5 underwriting guide generally accepted in the insurance industry as
6 designated by the commissioner, the scoring scale for which shall be
7 established by the commissioner.

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

16 ~~(26)~~~~(25)~~ "Index rate" means, for each class of business as to a rating period, the
17 arithmetic average of the applicable base premium rate and the corresponding
18 highest premium rate;

19 ~~(27)~~~~(26)~~ "Individual market" means the market for the health insurance coverage
20 offered to individuals other than in connection with a group health plan. The
21 individual market includes an association plan that is not employer related, issued to
22 individuals on an individually underwritten basis, other than an employer-organized
23 association or a bona fide association, that has been organized and is maintained in
24 good faith for purposes other than obtaining insurance for its members and that has
25 a constitution and bylaws;

26 **(28) "Insured" or "covered person" means an individual covered by a health benefit**
27 **plan;**

1 (29)~~[(27)]~~ "Insurer" means any insurance company; health maintenance organization;
2 self-insurer or multiple employer welfare arrangement not exempt from state
3 regulation by ERISA; provider-sponsored integrated health delivery network; self-
4 insured employer-organized association, or nonprofit hospital, medical-surgical,
5 dental, or health service corporation authorized to transact health insurance business
6 in Kentucky;

7 (30)~~[(28)]~~ "Insurer-controlled" means that the commissioner has found, in an
8 administrative hearing called specifically for that purpose, that an insurer has or had
9 a substantial involvement in the organization or day-to-day operation of the entity
10 for the principal purpose of creating a device, arrangement, or scheme by which the
11 insurer segments employer groups according to their actual or anticipated health
12 status or actual or projected health insurance premiums;

13 (31)~~[(29)]~~ "Kentucky Access" has the meaning provided in KRS 304.17B-001~~[(17)]~~;

14 (32)~~[(30)]~~ "Large group" means:

- 15 (a) An employer with fifty-one (51) or more employees;
16 (b) An affiliated group with fifty-one (51) or more eligible members; or
17 (c) An employer-organized association that is a bona fide association as defined
18 in ~~subsection (5) of~~ this section;

19 (33)~~[(31)]~~ "Managed care" means systems or techniques generally used by third-party
20 payors or their agents to affect access to and control payment for health care
21 services and that integrate the financing and delivery of appropriate health care
22 services to covered persons by arrangements with participating providers who are
23 selected to participate on the basis of explicit standards for furnishing a
24 comprehensive set of health care services and financial incentives for covered
25 persons using the participating providers and procedures provided for in the plan;

26 (34)~~[(32)]~~ "Market segment" means the portion of the market covering one (1) of the
27 following:

1 (a) Individual;

2 (b) Small group;

3 (c) Large group; or

4 (d) Association;

5 (35)~~[(33)]~~ "Participant" means any employee or former employee of an employer, or any
6 member or former member of an employee organization, who is or may become
7 eligible to receive a benefit of any type from an employee benefit plan which covers
8 employees of the employer or members of the organization, or whose beneficiaries
9 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

10 (36)~~[(34)]~~ "Preventive services" means medical services for the early detection of disease
11 that are associated with substantial reduction in morbidity and mortality;

12 (37)~~[(35)]~~ "Provider network" means an affiliated group of varied health care providers
13 that is established to provide a continuum of health care services to individuals;

14 (38)~~[(36)]~~ "Provider-sponsored integrated health delivery network" means any provider-
15 sponsored integrated health delivery network created and qualified under KRS
16 304.17A-300 and KRS 304.17A-310;

17 (39)~~[(37)]~~ "Purchaser" means an individual, organization, employer, association, or the
18 Commonwealth that makes health benefit purchasing decisions on behalf of a group
19 of individuals;

20 (40)~~[(38)]~~ "Rating period" means the calendar period for which premium rates are in
21 effect. A rating period shall not be required to be a calendar year;

22 (41)~~[(39)]~~ "Restricted provider network" means a health benefit plan that conditions the
23 payment of benefits, in whole or in part, on the use of the providers that have
24 entered into a contractual arrangement with the insurer to provide health care
25 services to covered individuals;

26 (42)~~[(40)]~~ "Self-insured plan" means a group health insurance plan in which the
27 sponsoring organization assumes the financial risk of paying for covered services

1 provided to its enrollees;

2 ~~(43)~~~~((41))~~ "Small employer" means, in connection with a group health plan with respect
3 to a calendar year and a plan year, an employer who employed an average of at least
4 two (2) but not more than fifty (50) employees on business days during the
5 preceding calendar year and who employs at least two (2) employees on the first day
6 of the plan year;

7 ~~(44)~~~~((42))~~ "Small group" means:

8 (a) A small employer with two (2) to fifty (50) employees; or

9 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

10 ~~(45)~~~~((43))~~ "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

11 ~~(46)~~~~((44))~~ "Telehealth" has the meaning provided in KRS 311.550.

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

14 **(1) For the purposes of this section, "registered air ambulance service provider"**
15 **means an air ambulance service provider licensed by the Kentucky Board of**
16 **Emergency Medical Services that has registered with the department to**
17 **participate in the voluntary dispute resolution process established pursuant to**
18 **subsection (9)(a) of this section.**

19 **(2) An insurer offering a health benefit plan that does not have an adequate network**
20 **of air ambulance service providers in this state, as determined by the department,**
21 **shall not use an allowed amount for air ambulance reimbursement that is less**
22 **than the applicable average rates published by registered air ambulance service**
23 **providers. The department shall determine the average rates on an annual basis.**

24 **(3) For purposes of this section, a patient transport shall be deemed to be medically**
25 **necessary by a health benefit plan if a neutral third-party licensed or certified**
26 **medical professional or first responder:**

27 **(a) Requests the transport; and**

1 **(b) Determines that the transport should be conducted by an air ambulance**
2 **service provider without regard to the patient's ability to pay.**

3 **(4) If an insured, after being picked up in the state, receives services from a**
4 **registered air ambulance service provider that is not a participating provider with**
5 **the insured's health benefit plan, the insurer shall assume the insured's**
6 **responsibility for amounts charged by the registered air ambulance service**
7 **provider less any applicable copayments, coinsurance, and deductibles.**

8 **(5) An insurer that has assumed a covered person's responsibility as required**
9 **pursuant to subsection (4) of this section shall notify the air ambulance service of**
10 **that assumption no later than the date the payment is required to be issued**
11 **pursuant to subsection (7) of this section.**

12 **(6) If a registered air ambulance service provider receives notice pursuant to**
13 **subsection (5) of this section, with the exception of amounts owed for applicable**
14 **copayments, coinsurance, and deductibles, the registered air ambulance service**
15 **shall not:**

16 **(a) Balance bill or attempt to balance bill the insured;**

17 **(b) Report to a consumer reporting agency that the insured is delinquent for the**
18 **amount assumed by the insurer pursuant to subsection (4) of this section;**

19 **(c) Obtain a lien on the insured's property in connection with the amount**
20 **assumed by the health benefit plan pursuant to subsection (4) of this**
21 **section; or**

22 **(d) Take any other action adverse to the insured with regard to the amount**
23 **assumed by the insurer pursuant to subsection (4) of this section.**

24 **(7) (a) Within the time frame required for payment of claims pursuant to KRS**
25 **304.17A-702, an insurer shall:**

26 **1. a. Remit payment directly to the air ambulance service**
27 **provider for the portion of the claim for which the insurer**

1 is responsible; or

2 b. Send denial of a claim for the air ambulance services; and

3 2. Notify the insured and the registered air ambulance service provider
4 of the amount of deductible, coinsurance, or copayment for which the
5 insured is responsible.

6 (b) An insurer that has assumed responsibility pursuant to subsection (4) of
7 this section shall determine the amount of payment based on:

8 1. The billed charges of the air ambulance service;

9 2. A differing amount negotiated with the registered air ambulance
10 service provider; or

11 3. If the adequacy requirements in subsection (2) of this section are
12 deemed by the department to have been met, the maximum allowed
13 amount under the health benefit plan for an in-network air
14 ambulance service provider for the services performed.

15 (8) If after payment has been made pursuant to subsection (7) of this section, the
16 insurer or registered air ambulance service provider disputes the reasonableness
17 of that payment, and good-faith settlement negotiations fail to resolve the dispute,
18 the insurer or registered air ambulance service provider shall invoke the
19 independent dispute resolution process established in subsection (9) of this
20 section.

21 (9) (a) The Independent Dispute Resolution Program for disputed air ambulance
22 services charges is hereby established in the department.

23 1. The department shall:

24 a. Promulgate rules, forms, and procedures for the implementation
25 and administration of the program; and

26 b. Maintain a list of qualified reviewers.

27 2. The department may charge any fee necessary to cover its costs of

- 1 implementation and administration of the program.
- 2 (b) 1. a. By January 1 of each year, air ambulance service providers
3 wanting to participate in the independent dispute resolution
4 program shall register with the department.
- 5 b. This registration shall automatically renew quarterly unless the
6 registered air ambulance service provider gives notice to the
7 department of its intent to not renew its registration not less than
8 thirty (30) days prior to the end of the quarter.
- 9 c. All disputed charges incurred during the quarter of a registered
10 air ambulance service provider's registration shall be subject to
11 the independent dispute resolution program.
- 12 2. By registering with the department, a registered air ambulance service
13 provider acknowledges that, notwithstanding the Airline Deregulation
14 Act, Pub. L. No. 95-504, it is voluntarily agreeing to participate in the
15 independent dispute resolution program, and the voluntary agreement
16 constitutes a waiver of the air ambulance service provider's ability to
17 challenge the independent dispute resolution program based on
18 federal preemption under 49 U.S.C. sec. 41713 with respect to disputed
19 charges.
- 20 3. As a further condition of participation in the independent dispute
21 resolution program, the registered air ambulance provider agrees:
- 22 a. To publish the air ambulance transport rates it charges in
23 Kentucky; and
- 24 b. To provide to the department itemized billings for each of its
25 transports in Kentucky, with any personally identifiable
26 information, as defined in KRS 365.720, removed or redacted.
- 27 4. The department shall keep and maintain records of each independent

- 1 dispute resolution proceeding.
- 2 5. The department shall analyze the results from the proceedings, as well
- 3 as the information submitted to it pursuant to paragraph (b)3. of this
- 4 subsection, and issue a report annually, the contents of which shall
- 5 include, but not be limited to:
- 6 a. The overall aggregate statistics of the program, for the year;
- 7 b. The results of all disputes decided by each independent reviewer
- 8 through the program with any identifying information of the
- 9 parties' removed;
- 10 c. The number of disputes settled between parties;
- 11 d. An analysis of financial and market trends of the air ambulance
- 12 service provider claims; and
- 13 e. Any recommended changes to improve the independent dispute
- 14 resolution program.
- 15 6. The report shall be made public through, at minimum, posting on the
- 16 department's Web site.
- 17 (c) The sole issue to be considered and determined in an independent dispute
- 18 resolution proceeding is the reasonable charge for the air ambulance
- 19 service provided. The basis for this determination shall include but not be
- 20 limited to the overall fixed and variable cost for providing the air
- 21 ambulance services including:
- 22 1. Costs of maintaining aircraft, hangar, and crew facilities;
- 23 2. Compensation for pilots and flight crew, taking into consideration
- 24 training and qualifications;
- 25 3. Overhead;
- 26 4. Insurance;
- 27 5. Fuel;

- 1 6. Costs attributable to any medical services provided in-flight;
2 7. Costs associated with readiness;
3 8. Cost of uncompensated care and undercompensated care; and
4 9. A reasonable profit.
- 5 (10) (a) Either the registered air ambulance service provider or the insurer may
6 request adjudication of a disputed charge by submitting a request for
7 independent dispute resolution on the forms or in the manner prescribed by
8 the department, and shall include the amount in dispute and a brief
9 description of the service provided. The requesting party shall copy the other
10 party on its submission to the department.
- 11 (b) The insurance commissioner shall establish an application process and fee
12 schedule for independent reviewers.
- 13 (c) If the parties have not designated an independent reviewer by mutual
14 agreement within thirty (30) days of the request submission, the
15 commissioner shall select an independent reviewer from its list of qualified
16 reviewers.
- 17 (d) To be eligible to serve as an independent reviewer, an individual must be
18 knowledgeable and experienced in applicable principles of contract law,
19 insurance law, and the healthcare industry generally.
- 20 1. In approving an individual as an independent reviewer, the
21 commissioner shall ensure that the individual does not have a conflict
22 of interest that would adversely impact the individual's independence
23 and impartiality in rendering a decision in an independent dispute
24 resolution procedure. A conflict of interest includes but is not limited
25 to current or recent ownership or employment of either the individual
26 or a close family member by an insurer, a health care provider, or an
27 air ambulance service provider that may be involved in an

- 1 independent dispute resolution procedure.
- 2 2. The commissioner shall immediately terminate the approval of an
- 3 independent reviewer who no longer meets the requirements to serve
- 4 as an independent reviewer.
- 5 (e) 1. Either party to a proceeding may request an oral hearing. If no oral
- 6 hearing is requested, the independent reviewer shall set a date for the
- 7 submission of all information to be considered by the independent
- 8 reviewer.
- 9 2. Each party shall submit a "binding award amount." The independent
- 10 reviewer shall choose one (1) of the parties' submitted "binding award
- 11 amount" based on which amount the independent reviewer
- 12 determines to be closest to the reasonable charge for air ambulance
- 13 services provided in accordance with subsection (9)(c) of this section,
- 14 with no deviation.
- 15 3. If an oral hearing is requested, the independent reviewer may make
- 16 procedural rulings.
- 17 4. There shall be no discovery in any independent dispute resolution
- 18 proceeding.
- 19 5. The independent reviewer shall issue his or her written decision within
- 20 ten (10) days of an oral hearing, or if no hearing is requested within
- 21 ten (10) days of the date for submission set by the reviewer.
- 22 (f) Unless otherwise agreed to by the parties, each party shall:
- 23 1. Pay its own attorney's fees and costs; and
- 24 2. Equally bear all fees and costs of the independent reviewer.
- 25 (g) The decision of the independent reviewer is final and shall be binding on all
- 26 parties. The prevailing party may seek enforcement of the reviewer's
- 27 decision in any court of competent jurisdiction.

1 ➔Section 3. KRS 304.17A-096 is amended to read as follows:

2 (1) An insurer authorized to engage in the business of insurance in the Commonwealth
3 of Kentucky may offer one (1) or more basic health benefit plans in the individual,
4 small group, and employer-organized association markets. A basic health benefit
5 plan shall cover physician, pharmacy, home health, preventive, emergency, and
6 inpatient and outpatient hospital services in accordance with the requirements of
7 this subtitle. If vision or eye services are offered, these services may be provided by
8 an ophthalmologist or optometrist.

9 (2) An insurer that offers a basic health benefit plan shall be required to offer health
10 benefit plans as defined in KRS 304.17A-005~~[(22)]~~.

11 (3) An insurer in the individual, small group, or employer-organized association
12 markets that offers a basic health benefit plan may offer a basic health benefit plan
13 that excludes from coverage any state-mandated health insurance benefit, except
14 that the basic health benefit plan shall include coverage for diabetes as provided in
15 KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic
16 benefits as provided in KRS 304.17A-171, mammograms as provided in KRS
17 304.17A-133, and those mandated benefits specified under federal law.

18 (4) Notwithstanding any other provisions of this section, mandated benefits excluded
19 from coverage shall not be deemed to include the payment, indemnity, or
20 reimbursement of specified health care providers for specific health care services.

21 ➔Section 4. KRS 304.17A-430 is amended to read as follows:

22 (1) A health benefit plan shall be considered a program plan and is eligible for
23 inclusion in calculating assessments and refunds under the program risk adjustment
24 process if it meets all of the following criteria:

25 (a) The health benefit plan was purchased by an individual to provide benefits for
26 only one (1) or more of the following: the individual, the individual's spouse,
27 or the individual's children. Health insurance coverage provided to an

- 1 individual in the group market or otherwise in connection with a group health
2 plan does not satisfy this criteria even if the individual, or the individual's
3 spouse or parent, pays some or all of the cost of the coverage unless the
4 coverage is offered in connection with a group health plan that has fewer than
5 two (2) participants as current employees on the first day of the plan year;
- 6 (b) An individual entitled to benefits under the health benefit plan has been
7 diagnosed with a high-cost condition on or before the effective date of the
8 individual's coverage for coverage issued on a guarantee-issue basis after July
9 15, 1995;
- 10 (c) The health benefit plan imposes the maximum pre-existing condition
11 exclusion permitted under KRS 304.17A-200;
- 12 (d) The individual purchasing the health benefit plan is not eligible for or covered
13 by other coverage; and
- 14 (e) The individual is not a state employee eligible for or covered by the state
15 employee health insurance plan under KRS Chapter 18A.
- 16 (2) Notwithstanding the provisions of subsection (1) of this section, if the total claims
17 paid for the high-cost condition under a program plan for any three (3) consecutive
18 years are less than the premiums paid under the program plan for those three (3)
19 consecutive years, then the following shall occur:
- 20 (a) The policy shall not be considered to be a program plan thereafter until the
21 first renewal of the policy after there are three (3) consecutive years in which
22 the total claims paid under the policy have exceeded the total premiums paid
23 for the policy and at the time of the renewal the policy also qualifies under
24 subsection (1) as a program plan; and
- 25 (b) Within the last six (6) months of the third year, the insurer shall provide each
26 person entitled to benefits under the policy who has a high-cost condition with
27 a written notice of insurability. The notice shall state that the recipient may be

1 able to purchase a health benefit plan other than a program plan and shall also
2 state that neither the notice nor the individual's actions to purchase a health
3 benefit plan other than a program plan shall affect the individual's eligibility
4 for plan coverage. The notice shall be valid for six (6) months.

5 (3) (a) There is established within the guaranteed acceptance program the alternative
6 underwriting mechanism that a participating insurer may elect to use. An
7 insurer that elects this mechanism shall use the underwriting criteria that the
8 insurer has used for the past twelve (12) months for purposes of the program
9 plan requirement in paragraph (b) of subsection (1) of this section for high-
10 risk individuals rather than using the criteria established in KRS 304.17A-
11 005~~[(24)]~~ and 304.17A-280 for high-cost conditions.

12 (b) An insurer that elects to use the alternative underwriting mechanism shall
13 make written application to the commissioner. Before the insurer may
14 implement the mechanism, the insurer shall obtain approval of the
15 commissioner. Annually thereafter, the insurer shall obtain the commissioner's
16 approval of the underwriting criteria of the insurer before the insurer may
17 continue to use the alternative underwriting mechanism.

18 ➔Section 5. KRS 304.17B-001 is amended to read as follows:

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

- 20 (1) "Administrator" is defined in KRS 304.9-051~~[(1)]~~;
- 21 (2) "Agent" is defined in KRS 304.9-020;
- 22 (3) "Assessment process" means the process of assessing and allocating guaranteed
23 acceptance program losses or Kentucky Access funding as provided for in KRS
24 304.17B-021;
- 25 (4) "Authority" means the Kentucky Health Care Improvement Authority;
- 26 (5) "Case management" means a process for identifying an enrollee with specific health
27 care needs and interacting with the enrollee and their respective health care

1 providers in order to facilitate the development and implementation of a plan that
2 efficiently uses health care resources to achieve optimum health outcome;

3 ~~(6) "Commissioner" is defined in KRS 304.1-050[(1)];~~

4 ~~(7) "Department" is defined in KRS 304.1-050[(2)];~~

5 ~~(8)~~ "Earned premium" means the portion of premium paid by an insured that has been
6 allocated to the insurer's loss experience, expenses, and profit year to date;

7 ~~(7)~~~~(9)~~ "Enrollee" means a person who is enrolled in a health benefit plan offered
8 under Kentucky Access;

9 ~~(8)~~~~(10)~~ "Eligible individual" is defined in KRS 304.17A-005~~[(11)]~~;

10 ~~(9)~~~~(11)~~ "Guaranteed acceptance program" or "GAP" means the Kentucky Guaranteed
11 Acceptance Program established and operated under KRS 304.17A-400 to
12 304.17A-480;

13 ~~(10)~~~~(12)~~ "Guaranteed acceptance program participating insurer" means an insurer that
14 offered health benefit plans through December 31, 2000, in the individual market to
15 guaranteed acceptance program qualified individuals;

16 ~~(11)~~~~(13)~~ "Health benefit plan" is defined in KRS 304.17A-005~~[(22)]~~;

17 ~~(12)~~~~(14)~~ "High-cost condition" means acquired immune deficiency syndrome (AIDS),
18 angina pectoris, ascites, chemical dependency, cirrhosis of the liver, coronary
19 insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia,
20 Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic
21 cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy,
22 myasthenia gravis, myotonia, open-heart surgery, Parkinson's disease, polycystic
23 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, Wilson's disease,
24 chronic renal failure, malignant neoplasm of the trachea, malignant neoplasm of the
25 bronchus, malignant neoplasm of the lung, malignant neoplasm of the colon, short
26 gestation period for a newborn child, and low birth weight of a newborn child;

27 ~~(13)~~~~(15)~~ "Incurred losses" means for Kentucky Access the excess of claims paid over

1 premiums received;

2 ~~(14)~~~~(16)~~ "Insurer" is defined in KRS 304.17A-005~~(27)~~;

3 ~~(15)~~~~(17)~~ "Kentucky Access" means the program established in accordance with KRS
4 304.17B-001 to 304.17B-031;

5 ~~(16)~~~~(18)~~ "Kentucky Access Fund" means the fund established in KRS 304.17B-021;

6 ~~(17)~~~~(19)~~ "Kentucky Health Care Improvement Authority" means the board established
7 to administer the program initiatives listed in KRS 304.17B-003~~(5)~~;

8 ~~(18)~~~~(20)~~ "Kentucky Health Care Improvement Fund" means the fund established for
9 receipt of the Kentucky tobacco master settlement moneys for program initiatives
10 listed in KRS 304.17B-003~~(5)~~;

11 ~~(19)~~~~(21)~~ "MARS" means the Management Administrative Reporting System
12 administered by the Commonwealth;

13 ~~(20)~~~~(22)~~ "Medicaid" means coverage in accordance with Title XIX of the Social
14 Security Act, 42 U.S.C. secs. 1396 et seq., as amended;

15 ~~(21)~~~~(23)~~ "Medicare" means coverage under both Parts A and B of Title XVIII of the
16 Social Security Act, 42 U.S.C. secs. 1395 et seq., as amended;

17 ~~(22)~~~~(24)~~ "Pre-existing condition exclusion" is defined in KRS 304.17A-220~~(6)~~;

18 ~~(23)~~~~(25)~~ "Standard health benefit plan" means a health benefit plan that meets the
19 requirements of KRS 304.17A-250;

20 ~~(24)~~~~(26)~~ "Stop-loss carrier" means any person providing stop-loss health insurance
21 coverage;

22 ~~(25)~~~~(27)~~ "Supporting insurer" means all insurers, stop-loss carriers, and self-insured
23 employer-controlled or bona fide associations; and

24 ~~(26)~~~~(28)~~ "Utilization management" is defined in KRS 304.17A-500~~(12)~~.

25 ➔Section 6. KRS 304.17B-015 is amended to read as follows:

26 (1) Any individual who is an eligible individual and a resident of Kentucky is eligible
27 for coverage under Kentucky Access, except as specified in paragraphs (a), (b), (d),

1 and (e) of subsection (4) of this section.

2 (2) Any individual who is not an eligible individual who has been a resident of the
3 Commonwealth for at least twelve (12) months immediately preceding the
4 application for Kentucky Access coverage is eligible for coverage under Kentucky
5 Access if one (1) of the following conditions is met:

6 (a) The individual has been rejected by at least one (1) insurer for coverage of a
7 health benefit plan that is substantially similar to Kentucky Access coverage;

8 (b) The individual has been offered coverage substantially similar to Kentucky
9 Access coverage at a premium rate greater than the Kentucky Access premium
10 rate at the time of enrollment or upon renewal; or

11 (c) The individual has a high-cost condition listed in KRS 304.17B-001.

12 (3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year
13 period shall be issued a notice of insurability. The notice shall indicate that the
14 Kentucky Access enrollee has not had claims exceed premium rates for a three (3)
15 year period and may be used by the enrollee to obtain insurance in the regular
16 individual market.

17 (4) An individual shall not be eligible for coverage under Kentucky Access if:

18 (a) 1. The individual has, or is eligible for, on the effective date of coverage
19 under Kentucky Access, substantially similar coverage under another
20 contract or policy, unless the individual was issued coverage from a
21 GAP participating insurer as a GAP qualified individual prior to January
22 1, 2001. A GAP qualified individual shall be automatically eligible for
23 coverage under Kentucky Access without regard to the requirements of
24 subsection (2) of this section; or

25 2. For individuals meeting the requirements of KRS 304.17A-005~~[(11)]~~,
26 the individual has, or is eligible for, on the effective date of coverage
27 under Kentucky Access, coverage under a group health plan.

1 An individual who is ineligible for coverage pursuant to this paragraph shall
2 not preclude the individual's spouse or dependents from being eligible for
3 Kentucky Access coverage. As used in this paragraph, "eligible for" includes
4 any individual and an individual's spouse or dependent who was eligible for
5 coverage but waived that coverage. That individual and the individual's
6 spouse or dependent shall be ineligible for Kentucky Access coverage through
7 the period of waived coverage;

8 (b) The individual is eligible for coverage under Medicaid or Medicare;

9 (c) The individual previously terminated Kentucky Access coverage and twelve
10 (12) months have not elapsed since the coverage was terminated, unless the
11 individual demonstrates a good faith reason for the termination;

12 (d) Except for covered benefits paid under the standard health benefit plan as
13 specified in KRS 304.17B-019, Kentucky Access has paid two million dollars
14 (\$2,000,000) in covered benefits per individual. The maximum limit under
15 this paragraph may be increased by the department;

16 (e) The individual is confined to a public institution or incarcerated in a federal,
17 state, or local penal institution or in the custody of federal, state, or local law
18 enforcement authorities, including work release programs; or

19 (f) The individual's premium, deductible, coinsurance, or copayment is partially
20 or entirely paid or reimbursed by an individual or entity other than the
21 individual or the individual's parent, grandparent, spouse, child, stepchild,
22 father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-
23 law, sister-in-law, grandchild, guardian, or court-appointed payor.

24 (5) The coverage of any person who ceases to meet the requirements of this section or
25 the requirements of any administrative regulation promulgated under this subtitle
26 may be terminated.

27 ➔Section 7. KRS 304.17B-033 is amended to read as follows:

1 (1) No less than annually, the Health Insurance Advisory Council shall review the list
2 of high-cost conditions established under KRS 304.17B-001~~[(14)]~~ and recommend
3 changes to the commissioner. The commissioner may accept or reject any or all of
4 the recommendations and may make whatever changes by administrative regulation
5 the commissioner deems appropriate. The council, in making recommendations, and
6 the commissioner, in making changes, shall consider, among other things, actual
7 claims and losses on each diagnosis and advances in treatment of high-cost
8 conditions.

9 (2) The commissioner may by administrative regulation add to or delete from the list of
10 high-cost conditions for Kentucky Access.

11 ➔Section 8. KRS 304.17C-010 is amended to read as follows:

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

13 (1) "At the time of enrollment" means the same as defined in KRS 304.17A-005~~[(2)]~~;

14 (2) "Enrollee" means an individual who is enrolled in a limited health service benefit
15 plan;

16 (3) "Health care provider" or "provider" means the same as defined in KRS 304.17A-
17 005~~[(23)]~~;

18 (4) "Insurer" means any insurance company, health maintenance organization, self-
19 insurer or multiple employer welfare arrangement not exempt from state regulation
20 by ERISA, provider-sponsored integrated health delivery network, self-insured
21 employer-organized association, nonprofit hospital, medical-surgical, dental, health
22 service corporation, or limited health service organization authorized to transact
23 health insurance business in Kentucky who offers a limited health service benefit
24 plan; and

25 (5) "Limited health service benefit plan" means any policy or certificate that provides
26 services for dental, vision, mental health, substance abuse, chiropractic,
27 pharmaceutical, podiatric, or other such services as may be determined by the

1 commissioner to be offered under a limited health service benefit plan. A limited
2 health service benefit plan shall not include hospital, medical, surgical, or
3 emergency services except as these services are provided incidental to the plan.

4 ➔Section 9. KRS 304.18-114 is amended to read as follows:

5 (1) As used in this section:

6 (a) "Conversion health insurance coverage" means a health benefit plan meeting
7 the requirements of this section and regulated in accordance with Subtitles 17
8 and 17A of this chapter;

9 (b) "Group policy" has the meaning provided in KRS 304.18-110; and

10 (c) "Medicare" has the meaning provided in KRS 304.18-110.

11 (2) An insurer providing group health insurance coverage shall offer a conversion
12 health insurance policy, by written notice, to any group member terminated under
13 the group policy for any reason. The insurer shall offer a conversion health
14 insurance policy substantially similar to the group policy. The former group
15 member shall meet the following conditions:

16 (a) The former group member had been a member of the group and covered under
17 any health insurance policy offered by the group for at least three (3) months;

18 (b) The former group member must make written application to the insurer for
19 conversion health insurance coverage not later than thirty-one (31) days after
20 notice pursuant to subsection (5) of this section; and

21 (c) The former group member must pay the monthly, quarterly, semiannual, or
22 annual premium, at the option of the applicant, to the insurer not later than
23 thirty-one (31) days after notice pursuant to subsection (5) of this section.

24 (3) An insurer shall offer the following terms of conversion health insurance coverage:

25 (a) Conversion health insurance coverage shall be available without evidence of
26 insurability and may contain a pre-existing condition limitation in accordance
27 with KRS 304.17A-230;

- 1 (b) The premium for conversion health insurance coverage shall be according to
2 the insurer's table of premium rates in effect on the latter of:
- 3 1. The effective date of the conversion policy; or
 - 4 2. The date of application when the premium rate applies to the class of
5 risk to which the covered persons belong, to their ages, and to the form
6 and amount of insurance provided;
- 7 (c) The conversion health insurance policy shall cover the former group member
8 and eligible dependents covered by the group policy on the date coverage
9 under the group policy terminated.
- 10 (d) The effective date of the conversion health insurance policy shall be the date
11 of termination of coverage under the group policy; and
- 12 (e) The conversion health insurance policy shall provide benefits substantially
13 similar to those provided by the group policy, but not less than the minimum
14 standards set forth in KRS 304.18-120 and any administrative regulations
15 promulgated thereunder.
- 16 (4) Conversion health insurance coverage need not be granted in the following
17 situations:
- 18 (a) On the effective date of coverage, the applicant is or could be covered by
19 Medicare;
 - 20 (b) On the effective date of coverage, the applicant is or could be covered by
21 another group coverage (insured or uninsured) or, the applicant is covered by
22 substantially similar benefits by another individual hospital, surgical, or
23 medical expenses insurance policy; or
 - 24 (c) The issuance of conversion health insurance coverage would cause the
25 applicant to be overinsured according to the insurer's standards, taking into
26 account that the applicant is or could be covered by similar benefits pursuant
27 to or in accordance with the requirements of any statute and the individual

1 coverage described in paragraph (b) of this subsection.

2 (5) Notice of the right to conversion health insurance coverage shall be given as
3 follows:

4 (a) For group policies delivered, issued for delivery, or renewed after July 15,
5 2002, the insurer shall give written notice of the right to conversion health
6 insurance coverage to any former group member entitled to conversion
7 coverage under this section upon notice from the group policyholder that the
8 group member has terminated membership in the group, upon termination of
9 the former group member's continued group health insurance coverage
10 pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-
11 005~~[(7)]~~, or upon termination of the group policy for any reason. The written
12 notice shall clearly explain the former group member's right to a conversion
13 policy.

14 (b) The thirty-one (31) day period of subsection (2)(b) of this section shall not
15 begin to run until the notice required by this subsection is mailed or delivered
16 to the last known address of the former group member.

17 (c) If a former group member becomes entitled to obtain conversion health
18 insurance coverage, pursuant to this section, and the insurer fails to give the
19 former group member written notice of the right, pursuant to this subsection,
20 the insurer shall give written notice to the former group member as soon as
21 practicable after being notified of the insurer's failure to give written notice of
22 conversion rights to the former group member and such former group member
23 shall have an additional period within which to exercise his conversion rights.
24 The additional period shall expire sixty (60) days after written notice is
25 received from the insurer. Written notice delivered or mailed to the last known
26 address of the former group member shall constitute the giving of notice for
27 the purpose of this paragraph. If a former group member makes application

1 and pays the premium, for conversion health insurance coverage within the
2 additional period allowed by this paragraph, the effective date of conversion
3 health insurance coverage shall be the date of termination of group health
4 insurance coverage. However, nothing in this subsection shall require an
5 insurer to give notice or provide conversion coverage to a former group
6 member ninety (90) days after termination of the former group member's
7 group coverage.

8 ➔Section 10. KRS 304.38A-010 is amended to read as follows:

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

- 10 (1) "Enrollee" means an individual who is enrolled in a limited health services benefit
11 plan;
- 12 (2) "Evidence of coverage" means any certificate, agreement, contract, or other
13 document issued to an enrollee stating the limited health services to which the
14 enrollee is entitled. All coverages described in an evidence of coverage issued by a
15 limited health service organization are deemed to be "limited health services benefit
16 plans" to the extent defined in KRS 304.17C-010 unless exempted by the
17 commissioner;
- 18 (3) "Limited health service" means dental care services, vision care services, mental
19 health services, substance abuse services, chiropractic services, pharmaceutical
20 services, podiatric care services, and such other services as may be determined by
21 the commissioner to be limited health services. Limited health service shall not
22 include hospital, medical, surgical, or emergency services except as these services
23 are provided incidental to the limited health services set forth in this subsection;
- 24 (4) "Limited health service contract" means any contract entered into by a limited
25 health service organization with a policyholder to provide limited health services;
- 26 (5) "Limited health service organization" means a corporation, partnership, limited
27 liability company, or other entity that undertakes to provide or arrange limited

1 health service or services to enrollees. A limited health service organization does
2 not include a provider or an entity when providing or arranging for the provision of
3 limited health services under a contract with a limited health service organization,
4 health maintenance organization, or a health insurer; and

5 (6) "Provider" means the same as defined in KRS 304.17A-005~~[(23)]~~.

6 ➔Section 11. KRS 304.39-241 is amended to read as follows:

7 An insured may direct the payment of benefits among the different elements of loss, if the
8 direction is provided in writing to the reparation obligor. A reparation obligor shall honor
9 the written direction of benefits provided by an insured on a prospective basis. The
10 insured may also explicitly direct the payment of benefits for related medical expenses
11 already paid arising from a covered loss to reimburse:

12 (1) A health benefit plan as defined by KRS 304.17A-005~~[(22)]~~;

13 (2) A limited health service benefit plan as defined by KRS 304.17C-010;

14 (3) Medicaid;

15 (4) Medicare; or

16 (5) A Medicare supplement provider.

17 ➔Section 12. This Act takes effect January 1, 2019.