304.17A-255 Definition of "cost sharing" and "plan year" -- Payments from specified federal programs on behalf of an insured count toward insured's premium and cost-sharing requirement -- Payments made by any person on behalf of insured permissible -- Exceptions -- Insured's responsibility towards premium payments.

(1) As used in this section:

(a) "Cost sharing" means the cost to an individual insured under a health benefit plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan; and

(b) "Plan year" means the year that is designated as the plan year in the plan document of a health benefit plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible or limit year used under the plan;
2. If the plan does not impose deductibles or limits on a yearly basis, the policy year;
3. If the plan does not impose deductibles or limits on a yearly basis and either the plan is not insured or the insurance policy is not renewed on an annual basis, the employer or sponsor's taxable year; or
4. If none of the preceding subparagraphs apply, the calendar year.

(2) Except as provided in subsection (4) of this section, all health benefit plans shall accept, and count towards the insured's contributions to any applicable premium or cost-sharing requirement, premium and cost-sharing payments made on behalf of an insured from the following:

(a) A state or federal government program, including payments made by programs operating in accordance with Title XXVI of the federal Public Health Service Act, 42 U.S.C. secs. 300ff et. seq., as amended;

(b) An Indian tribe, tribal organization, or urban Indian organization; and

(c) A program conducted by an organization that certifies that the organization:

1. Is exempt from taxation under 26 U.S.C. sec. 501(a), as amended;
2. Is described in 26 U.S.C. sec. 170(b)(1)(A)(i) or (vi);
3. Is operating in compliance with applicable federal laws, including the False Claims Act, 31 U.S.C. secs. 3729 to 3733; and
4. If the organization is not a church or a convention or association of churches, as described in 26 U.S.C. sec. 170(b)(1)(A)(i), is in compliance with at least one (1) of the following:

   a. The organization does not receive funding in any form from a health care provider, as defined in KRS 304.17A-005;

   b. Any premium assistance offered by the organization to an insured is sufficient to cover the insured's premiums payments for a full plan year; or

   c. The organization has been issued an advisory opinion under 42

U.S.C. sec. 1320a-7d(b), as amended, determining that the:

i. Program conducted by the organization is not prohibited remuneration in violation of federal law;

ii. Program conducted by the organization would not constitute grounds for the imposition of civil monetary penalties under 42 U.S.C. sec. 1320a-7a(a)(5), as amended; or

iii. Issuing agency would not impose sanctions in connection with the program conducted by the organization.

(3) To the extent permitted under federal law, all health benefit plans may accept, and count towards the insured's contributions to any applicable premium or cost-sharing requirement, premium and cost-sharing payments made on behalf of an insured by any person not referenced in subsection (2) of this section.

(4) If the application of any requirement of subsection (2) of this section would be the sole cause of a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied.

(5) Nothing in this section shall be construed to imply that the insured is not responsible for the timely payment of premiums in accordance with the terms of the health benefit plan contract between the insurer and the insured, even if the payment is made on behalf of the insured by a person referenced in subsection (2) of this section.

Effective: July 14, 2022

History: Amended 2022 Ky. Acts ch. 49, sec. 1, effective July 14, 2022. -- Created 2021 Ky. Acts ch. 133, sec. 1, effective January 1, 2022.

Legislative Research Commission Note (7/14/2022). 2022 Ky. Acts ch. 49, sec. 2, provides that this statute applies to health benefit plans issued or renewed on or after July 14, 2022.