AN ACT relating to maternal and child health.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

(1) The Kentucky maternal psychiatry access program, also known as the Kentucky Lifeline for Moms, is hereby established. The purpose of the program shall be to help health care practitioners in the Commonwealth meet the needs of a mother with mental illness or an intellectual disability.

(2) The program shall be operated by the Cabinet for Health and Family Services, Department for Public Health, Division of Maternal and Child Health.

(3) The program shall at a minimum employ a psychiatrist licensed pursuant to KRS Chapter 311 and a psychologist licensed pursuant to KRS Chapter 319.

(4) The program shall operate a dedicated hotline phone number Monday through Friday from 8 a.m. to 5 p.m. local time that serves as the entry point to the program for health care practitioners to be able to get services for a mother with mental illness or with an intellectual disability. Services shall include:

(a) An immediate clinical consultation over the telephone;

(b) An expedited face-to-face mental health consultation;

(c) Care coordination for assistance with referrals to community behavioral health services; and

(d) Continuing professional education specifically designed for health care practitioners.

(5) The department shall, within sixty (60) days of the effective date of this Act, promulgate administrative regulations in accordance with KRS Chapter 13A to implement the provisions of this section.

➔Section 2. KRS 211.122 is amended to read as follows:

(1) The Cabinet for Health and Family Services shall, in cooperation with maternal and

infant health and mental health professional societies:

(a) Develop written information on perinatal mental health disorders and make it available on its website for access by birthing centers, hospitals that provide labor and delivery services, and the public; and

(b) Provide access on its website to one (1) or more evidence-based clinical assessment tools designed to detect the symptoms of perinatal mental health disorders for use by health care providers providing perinatal care and health care providers providing pediatric infant care.

(2) The Cabinet for Health and Family Services shall establish ***the Kentucky maternal and infant health collaborative. The collaborative shall be composed of the following members:*** ~~[a collaborative panel composed of]~~

(a) Four (4) representatives of health care facilities that provide obstetrical***,*** ~~[and]~~newborn~~[care]~~, maternal***,*** and infant health care***;***

(b) Two (2) providers ***of*** ~~[,]~~ maternal mental health ***care;***

(c) Two (2) ~~[providers,]~~representatives of university mental health training programs***;***

(d) Two (2) ~~[,]~~ maternal health advocates***; and***

(e) Three (3) ~~[,]~~ women with ***each woman having*** experience living with ***at least one (1) of the following:***

1. Perinatal mental health disorders***;***

2. Substance use disorder; and

3. Intimate partner violence.

(3) The ~~[, and other stakeholders for the]~~ purposes of ***the collaborative shall be***:

(a) Improving the quality of prevention and treatment of perinatal mental health disorders;

(b) Promoting the implementation of evidence-based bundles of care to improve patient safety;

(c) Identifying unaddressed gaps in service related to perinatal mental health disorders that are linked to geographic, racial, and ethnic inequalities; lack of screenings; and insufficient access to treatments, professionals, or support groups; and

(d) Exploring grant and other funding opportunities and making recommendations for funding allocations to address the need for services and supports for perinatal mental health disorders.

(4) ~~[(3)]~~ ***The collaborative shall annually review the operations of the Kentucky maternal psychiatry access program established in Section 1 of this Act.***

(5) The objectives set forth in subsection ***(3)*** ~~[(2)(a) to (d)]~~ of this section may be achieved by incorporating the ***collaborative's*** ~~[panel's]~~ findings and recommendations into other programs administered by the Cabinet for Health and Family Services that are intended to improve maternal health care quality and safety.

(6) ~~[(4)]~~ On or before November 1 of each year, the ***collaborative*** ~~[panel]~~ shall submit a report to the Interim Joint Committee on Families and Children, the Interim Joint Committee on Health Services, and the Advisory Council for Medical Assistance describing the ***collaborative's*** ~~[panel's]~~ work and any recommendations to address identified gaps in services and supports for perinatal mental health disorders.

➔Section 3. KRS 211.690 is amended to read as follows:

(1) There is established within the Cabinet for Health and Family Services the Health Access Nurturing Development Services (HANDS) program as a voluntary statewide home visitation program, for the purpose of providing assistance to at-risk parents during the prenatal period and until the child's third birthday. The HANDS program recognizes that parents are the primary decision-makers for their children. The goals of the HANDS program ***shall be*** ~~[are]~~ to:

(a) Facilitate safe and healthy delivery of babies;

(b) Provide information about optimal child growth and human development;

(c) Facilitate the safety and health of homes;~~[and]~~

(d) Encourage greater self-sufficiency of families.

(2) The cabinet shall administer the HANDS program in cooperation with the Cabinet for Health and Family Services and the local public health departments. The voluntary home visitation program may supplement, but shall not duplicate, any existing program that provides assistance to parents of young children.

(3) The HANDS program shall include ~~[an]~~educational ***components***~~[component]~~ on***:***

(a) ~~[.]~~The recognition and prevention of pediatric abusive head trauma, as defined in KRS 620.020***;***

(b) Information related to lactation counseling, lactation consultation, and breastfeeding information; and

(c) Information related to the importance of safe sleep for babies as a way to prevent sudden infant death syndrome as defined in KRS 213.011.

(4) Participants in the HANDS program shall express informed consent to participate by written agreement on a form promulgated by the Cabinet for Health and Family Services.

(5) Participants in the HANDS program shall participate in the home visitation program through in-person face-to-face methods or through tele-service delivery methods. For the purposes of this subsection, "tele-service" means a home visitation service provided through video communication with the HANDS provider, parent, and child present in real time.

➔SECTION 4. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Exchange":

1. Means a governmental agency or nonprofit entity that makes qualified health plans, as defined in 42 U.S.C. sec. 18021, as amended, available

to qualified individuals or qualified employers; and

2. Includes:

a. An exchange serving the individual market for qualified individuals; and

b. A small business health options program serving the small group market for qualified employers; and

(b) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of this section, the term includes:

1. Short-term limited-duration coverage; and

2. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure.

(2) To the extent permitted by federal law:

(a) The following shall provide a special enrollment period to pregnant individuals who are eligible for coverage:

1. Any insurer offering a health benefit plan; and

2. Any exchange operating in this state;

(b) Except as provided in paragraph (c) of this subsection, the insurer or exchange shall allow the pregnant individual, and any individual who is eligible for coverage because of a relationship to the pregnant individual, to enroll for coverage under the plan or on the exchange at any time during the pregnancy;

(c) If the insurer or exchange is required under federal law to limit the enrollment period to a period that is less than the period provided in paragraph (b) of this subsection:

1. The enrollment period shall not be less than the maximum period of time permitted under the federal law; and

2. The enrollment period shall begin not earlier than the date that the individual receives confirmation of the pregnancy from a medical professional;

(d) The coverage required under this subsection shall begin no later than the first day of the first calendar month in which a medical professional determines that the pregnancy began, except that a pregnant individual may direct coverage to begin on the first day of any month occurring after that date but during the pregnancy; and

(e) If a directive under paragraph (d) of this subsection falls outside of the pregnancy period, the coverage required under this subsection shall begin no later than the first day of the last month that occurred during the pregnancy.

(3) For group health plans and insurers offering group health insurance coverage in Kentucky, the plan or insurer shall, at or before the time an individual is initially offered the opportunity to enroll in the plan or coverage, provide the individual with a notice of the special enrollment rights under this section.

(4) (a) Nothing in this section shall be construed to imply that the insured is not responsible for the payment of premiums for each month during which coverage is provided.

(b) For any coverage provided under this section, the original or first premium shall become due and owing not earlier than thirty (30) days after the date of enrollment.

➔Section 5. KRS 304.17A-145 is amended to read as follows:

(1) ***As used in this section, "health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of this section, the term includes:***

(a) Short-term limited-duration coverage; and

(b) Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to

insure.

(2) (a) A health benefit plan ***shall provide***~~[issued or renewed on or after July 15, 1996, that provides]~~ maternity coverage**.**

(b) The coverage required by this subsection includes coverage for:~~[shall provide]~~

1. All individuals covered under the plan, including dependents, regardless of age;

2. Maternity care associated with pregnancy, childbirth, and postpartum care;

3. Labor and delivery;

4. All breastfeeding services and supplies required under 42 U.S.C. sec. 300gg-13(a) and any related federal regulations, as amended; and

5. ~~[Coverage for]~~***Except as provided in subsection (3) of this section,*** inpatient care for a mother and her newly-born child for a minimum of**:**

a. Forty-eight (48) hours after vaginal delivery***; or***~~[and a minimum of]~~

b. Ninety-six (96) hours after delivery by Cesarean section.

(3)~~[(2)]~~ The provisions of subsection ***(2)(b)5.***~~[(1)]~~ of this section shall not apply to a health benefit plan if**:**

(a) The~~[health benefit]~~ plan authorizes an initial postpartum home visit which would include the collection of an adequate sample for the hereditary and metabolic newborn screening**;** and~~[if]~~

(b) The attending physician, with the consent of the mother of the ***newly born***~~[newly-born]~~ child, authorizes a shorter length of stay~~[than that required of health benefit plans in subsection (1) of this section]~~ upon the physician's determination that the mother and newborn meet the criteria for medical stability in the most current version of "Guidelines for Perinatal Care" prepared

by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

➔Section 6. KRS 304.17A-220 is amended to read as follows:

(1) All group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with ***Section 4 of this Act and*** the provisions of this section.

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

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

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

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

(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;

(c) 1. The period of any pre-existing condition exclusion that would otherwise apply to an individual is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under subsection (3) of this section; and

2. Except for ineligible individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would

otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and

(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.

(3) In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one (1) or more types of creditable coverage. For purposes of counting creditable coverage:

(a) If on a particular day the individual has creditable coverage from more than one (1) source, all the creditable coverage on that day is counted as one (1) day;

(b) Any days in a waiting period for coverage are not creditable coverage;

(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and

(d) Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.

(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or

evidence of creditable coverage.

(6) For purposes of this section:

(a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan;

(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change;

(c) "First day of coverage" means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;

(d) "Late enrollee" means an individual whose enrollment in a plan is a late enrollment;

(e) "Late enrollment" means enrollment of an individual under a group health plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

2. Through special enrollment;

(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable coverage; and

(g) "Waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:

1. If the application results in coverage, the date coverage begins; or

2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.

(7) (a) 1. Except as otherwise provided under subsection (3) of this section, for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.

3. In the case of an election with respect to a group health plan under subparagraph 2. of this paragraph, whether or not health insurance coverage is provided in connection with the plan, the plan shall:

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

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

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

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

(b) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, within thirty (30) days after the adoption or placement for adoption, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a

significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child. This shall not apply to coverage before the date of the adoption or placement for adoption.

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

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

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

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

a. At the time an individual ceases to be covered under a health benefit plan or otherwise becomes eligible under a COBRA continuation provision;

b. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision; and

c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage

described in subdivision a. or b. of this subparagraph, whichever is later.

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

2. The certification described in this subparagraph is a written certification of:

a. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the COBRA continuation provision; and

b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.

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

1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or insurer information on coverage of classes and categories of health

benefits available under the entity's plan or coverage; and

2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.

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

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

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child, death of the employee, termination of employment, reduction in the number of hours of employment,

employer contributions toward the coverage were terminated, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

c. Was offered through a health maintenance organization or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

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

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

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is

eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

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

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

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

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

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) At or before the time an employee is initially offered the opportunity to enroll

in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

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

1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health status-related factors; and

3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

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

2. This period shall begin on the enrollment date.

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

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

➔Section 7. KRS 18A.225 (Effective January 1, 2025) is amended to read as follows:

(1) (a) The term "employee" for purposes of this section means:

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;
2. Any certified or classified employee of a local board of education or a public charter school as defined in KRS 160.1590;
3. Any elected member of a local board of education;
4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky

Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(2)(b)3. and 78.5536(2)(b)3., unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees and retirees who are entitled to participate in the state-sponsored health insurance program;

(b) The term "health benefit plan" for the purposes of this section means a health benefit plan as defined in KRS 304.17A-005;

(c) The term "insurer" for the purposes of this section means an insurer as defined in KRS 304.17A-005; and

(d) The term "managed care plan" for the purposes of this section means a managed care plan as defined in KRS 304.17A-500.

(2) (a) The secretary of the Finance and Administration Cabinet, upon the recommendation of the secretary of the Personnel Cabinet, shall procure, in compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090, from one (1) or more insurers authorized to do business in this state, a group health benefit plan that may include but not be limited to health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), and exclusive provider organization (EPO) benefit plans encompassing all or any class or classes of employees. With the exception of employers governed by the provisions of KRS Chapters 16, 18A, and 151B, all employers of any class of employees or former employees shall enter into a contract with the Personnel Cabinet prior to including that group in the state health insurance group. The contracts shall include but not be limited to designating the entity

responsible for filing any federal forms, adoption of policies required for proper plan administration, acceptance of the contractual provisions with health insurance carriers or third-party administrators, and adoption of the payment and reimbursement methods necessary for efficient administration of the health insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

(b) The policy or policies shall be approved by the commissioner of insurance and may contain the provisions the commissioner of insurance approves, whether or not otherwise permitted by the insurance laws.

(c) Any carrier bidding to offer health care coverage to employees shall agree to provide coverage to all members of the state group, including active employees and retirees and their eligible covered dependents and beneficiaries, within the county or counties specified in its bid. Except as provided in subsection (20) of this section, any carrier bidding to offer health care coverage to employees shall also agree to rate all employees as a single entity, except for those retirees whose former employers insure their active employees outside the state-sponsored health insurance program and as otherwise provided in KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

(d) Any carrier bidding to offer health care coverage to employees shall agree to

provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance with data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions to protect the confidentiality of each individual employee; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier and shall develop methods to protect the confidentiality of the individual. The Personnel Cabinet shall include in the October annual report submitted pursuant to the provisions of KRS 18A.226 to the Governor, the General Assembly, and the Chief Justice of the Supreme Court, an analysis of the financial stability of the program, which shall include but not be limited to loss ratios, methods of risk adjustment, measurements of carrier quality of service, prescription coverage and cost management, and statutorily required mandates. If state self-insurance was available as a carrier option, the report also shall provide a detailed financial analysis of the self-insurance fund including but not limited to loss ratios, reserves, and reinsurance agreements.

(f) If any agency participating in the state-sponsored employee health insurance program for its active employees terminates participation and there is a state appropriation for the employer's contribution for active employees' health

insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

(g) Any funds in flexible spending accounts that remain after all reimbursements have been processed shall be transferred to the credit of the state-sponsored health insurance plan's appropriation account.

(h) Each entity participating in the state-sponsored health insurance program shall provide an amount at least equal to the state contribution rate for the employer portion of the health insurance premium. For any participating entity that used the state payroll system, the employer contribution amount shall be equal to but not greater than the state contribution rate.

(3) The premiums may be paid by the policyholder:

(a) Wholly from funds contributed by the employee, by payroll deduction or otherwise;

(b) Wholly from funds contributed by any department, board, agency, public postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government; or

(c) Partly from each, except that any premium due for health care coverage or dental coverage, if any, in excess of the premium amount contributed by any department, board, agency, postsecondary education institution, or branch of state, city, urban-county, charter county, county, or consolidated local government for any other health care coverage shall be paid by the employee.

(4) If an employee moves his or her place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he or she has elected coverage, into either the service area of another managed health care plan or into an area of the Commonwealth not within a managed health care plan service area, the employee shall be given an option, at the time of the move or transfer, to

change his or her coverage to another health benefit plan.

(5) No payment of premium by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall constitute compensation to an insured employee for the purposes of any statute fixing or limiting the compensation of such an employee. Any premium or other expense incurred by any department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall be considered a proper cost of administration.

(6) The policy or policies may contain the provisions with respect to the class or classes of employees covered, amounts of insurance or coverage for designated classes or groups of employees, policy options, terms of eligibility, and continuation of insurance or coverage after retirement.

(7) Group rates under this section shall be made available to the disabled child of an employee regardless of the child's age if the entire premium for the disabled child's coverage is paid by the state employee. A child shall be considered disabled if he or she has been determined to be eligible for federal Social Security disability benefits.

(8) The health care contract or contracts for employees shall be entered into for a period of not less than one (1) year.

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or the secretary's designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the

Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

(10) Notwithstanding any other provision of law to the contrary, the policy or policies provided to employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the purpose of obtaining or performing an abortion on behalf of employees or their dependents.

(11) Interruption of an established treatment regime with maintenance drugs shall be grounds for an insured to appeal a formulary change through the established appeal procedures approved by the Department of Insurance, if the physician supervising the treatment certifies that the change is not in the best interests of the patient.

(12) Any employee who is eligible for and elects to participate in the state health insurance program as a retiree, or the spouse or beneficiary of a retiree, under any one (1) of the state-sponsored retirement systems shall not be eligible to receive the state health insurance contribution toward health care coverage as a result of any other employment for which there is a public employer contribution. This does not preclude a retiree and an active employee spouse from using both contributions to the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.

(13) (a) The policies of health insurance coverage procured under subsection (2) of this

section shall include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.

(b) A health insurer shall not discriminate against any retail pharmacy located within the geographic coverage area of the health benefit plan and that meets the terms and conditions for participation established by the insurer, including price, dispensing fee, and copay requirements of a mail-order option. The retail pharmacy shall not be required to dispense by mail.

(c) The mail-order option shall not permit the dispensing of a controlled substance classified in Schedule II.

(14) The policy or policies provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining a hearing aid and acquiring hearing aid-related services for insured individuals under eighteen (18) years of age, subject to a cap of one thousand four hundred dollars ($1,400) every thirty-six (36) months pursuant to KRS 304.17A-132.

(15) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for the diagnosis and treatment of autism spectrum disorders consistent with KRS 304.17A-142.

(16) Any policy provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining amino acid-based elemental formula pursuant to KRS 304.17A-258.

(17) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a contiguous county that does provide those services, and the state contribution for the plan shall be the amount available in the county

where the plan selected is located.

(18) If a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

(19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and in the best interests of the state group to allow any carrier bidding to offer health care coverage under this section to submit bids that may vary county by county or by larger geographic areas.

(20) Notwithstanding any other provision of this section, the bid for proposals for health insurance coverage for calendar year 2004 shall include a bid scenario that reflects the statewide rating structure provided in calendar year 2003 and a bid scenario that allows for a regional rating structure that allows carriers to submit bids that may vary by region for a given product offering as described in this subsection:

(a) The regional rating bid scenario shall not include a request for bid on a statewide option;

(b) The Personnel Cabinet shall divide the state into geographical regions which shall be the same as the partnership regions designated by the Department for Medicaid Services for purposes of the Kentucky Health Care Partnership Program established pursuant to 907 KAR 1:705;

(c) The request for proposal shall require a carrier's bid to include every county within the region or regions for which the bid is submitted and include but not be restricted to a preferred provider organization (PPO) option;

(d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the

carrier all of the counties included in its bid within the region. If the Personnel Cabinet deems the bids submitted in accordance with this subsection to be in the best interests of state employees in a region, the cabinet may award the contract for that region to no more than two (2) carriers; and

(e) Nothing in this subsection shall prohibit the Personnel Cabinet from including other requirements or criteria in the request for proposal.

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

(22) Any fully insured health benefit plan or self-insured plan issued or renewed to public employees pursuant to this section shall comply with:

(a) KRS 304.12-237;

(b) KRS 304.17A-270 and 304.17A-525;

(c) KRS 304.17A-600 to 304.17A-633;

(d) KRS 205.593;

(e) KRS 304.17A-700 to 304.17A-730;

(f) KRS 304.14-135;

(g) KRS 304.17A-580 and 304.17A-641;

(h) KRS 304.99-123;

(i) KRS 304.17A-138;

(j) KRS 304.17A-148;

(k) KRS 304.17A-163 and 304.17A-1631;

(l) KRS 304.17A-265;

(m) KRS 304.17A-261;

(n) KRS 304.17A-262;~~[and]~~

(o) ***Section 4 of this Act;***

(p) Section 5 of this Act; and

(q) Administrative regulations promulgated pursuant to statutes listed in this subsection.

➔Section 8. KRS 164.2871 (Effective January 1, 2025) is amended to read as follows:

(1) The governing board of each state postsecondary educational institution is authorized to purchase liability insurance for the protection of the individual members of the governing board, faculty, and staff of such institutions from liability for acts and omissions committed in the course and scope of the individual's employment or service. Each institution may purchase the type and amount of liability coverage deemed to best serve the interest of such institution.

(2) All retirement annuity allowances accrued or accruing to any employee of a state postsecondary educational institution through a retirement program sponsored by the state postsecondary educational institution are hereby exempt from any state, county, or municipal tax, and shall not be subject to execution, attachment, garnishment, or any other process whatsoever, nor shall any assignment thereof be enforceable in any court. Except retirement benefits accrued or accruing to any employee of a state postsecondary educational institution through a retirement program sponsored by the state postsecondary educational institution on or after January 1, 1998, shall be subject to the tax imposed by KRS 141.020, to the extent provided in KRS 141.010 and 141.0215.

(3) Except as provided in KRS Chapter 44, the purchase of liability insurance for members of governing boards, faculty and staff of institutions of higher education in this state shall not be construed to be a waiver of sovereign immunity or any other immunity or privilege.

(4) The governing board of each state postsecondary education institution is authorized to provide a self-insured employer group health plan to its employees, which plan shall:

(a) Conform to the requirements of Subtitle 32 of KRS Chapter 304; and

(b) Except as provided in subsection (5) of this section, be exempt from conformity with Subtitle 17A of KRS Chapter 304.

(5) A self-insured employer group health plan provided by the governing board of a state postsecondary education institution to its employees shall comply with:

(a) KRS 304.17A-163 and 304.17A-1631;

(b) KRS 304.17A-265;

(c) KRS 304.17A-261;~~[and]~~

(d) KRS 304.17A-262***;***

(e) Section 4 of this Act; and

(f) Section 5 of this Act.

➔Section 9. KRS 194A.099 is amended to read as follows:

(1) The Division of Health Benefit Exchange ***within the Office of Data Analytics*** shall administer the provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.

(2) The Division of Health Benefit Exchange shall:

(a) Facilitate enrollment in health coverage and the purchase and sale of qualified health plans in the individual market;

(b) Facilitate the ability of eligible individuals to receive premium tax credits and cost-sharing reductions and enable eligible small businesses to receive tax credits, in compliance with all applicable federal and state laws and regulations;

(c) Oversee the consumer assistance programs of navigators, in-person assisters, certified application counselors, and insurance agents as appropriate;

(d) At a minimum, carry out the functions and responsibilities required pursuant to

42 U.S.C. sec. 18031 to implement and comply with federal regulations in accordance with 42 U.S.C. sec. 18041;~~[and]~~

(e) Regularly consult with stakeholders in accordance with 45 C.F.R. sec. 155.130**;** ***and***

(f) Comply with Section 4 of this Act.

(3) The Office ***of Data Analytics:***

(a) May enter into contracts and other agreements with appropriate entities, including but not limited to federal, state, and local agencies, as permitted under 45 C.F.R. sec. 155.110, to the extent necessary to carry out the duties and responsibilities of the office ***if***~~[, provided that]~~ the agreements incorporate adequate protections with respect to the confidentiality of any information to be shared**;**~~[.]~~

(b)~~[(4)]~~ ~~[The office]~~Shall pursue all available federal funding for the further development and operation of the Division of Health Benefit Exchange**;**~~[.]~~

(c)~~[(5)]~~ ~~[The Office of Health Data and Analytics]~~Shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement this section***; and***~~[.]~~

(d)~~[(6)]~~ ~~[The office]~~Shall not establish procedures and rules that conflict with or prevent the application of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148.

➔Section 10. KRS 205.522 (Effective January 1, 2024) is amended to read as follows:

(1) ***With respect to the administration and provision of Medicaid benefits pursuant to this chapter,*** the Department for Medicaid Services**,**~~[and]~~ any managed care organization contracted to provide Medicaid benefits pursuant to this chapter***, and the state's medical assistance program*** shall ***be subject to, and*** comply with**,** the ***following, as applicable:***~~[provisions of]~~

(a) KRS 304.17A-163***;***~~[,]~~

(b) KRS 304.17A-1631***;***~~[,]~~

(c) KRS 304.17A-167***;***~~[,]~~

(d) KRS 304.17A-235***;***~~[,]~~

(e) KRS 304.17A-257***;***~~[,]~~

(f) KRS 304.17A-259***;***~~[,]~~

(g) KRS 304.17A-263***;***~~[,]~~

(h) KRS 304.17A-515***;***~~[,]~~

(i) KRS 304.17A-580***;***~~[,]~~

(j) KRS 304.17A-600, 304.17A-603, ***and*** 304.17A-607***;***~~[, and]~~

(k) KRS 304.17A-740 to 304.17A-743***; and***~~[, as applicable]~~

(l) Section 5 of this Act.

(2) A managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the reporting requirements of KRS 304.17A-732.

➔Section 11. KRS 205.592 is amended to read as follows:

(1) Except as provided in subsection (2) of this section, pregnant women, new mothers up to twelve (12) months postpartum, and children up to age one (1) shall be eligible for participation in the Kentucky Medical Assistance Program if:

(a)~~[(1)]~~ They have family income up to but not exceeding one hundred and eighty-five percent (185%) of the nonfarm income official poverty guidelines as promulgated by the Department of Health and Human Services of the United States as revised annually; and

(b)~~[(2)]~~ They are otherwise eligible for the program.

(2) The percentage established in subsection (1)(a) of this section may be increased to the extent:

(a) Permitted under federal law; and

(b) Funding is available.

➔Section 12. KRS 205.6485 is amended to read as follows:

(1) ***As used in this section, "KCHIP" means the Kentucky Children's Health Insurance Program.***

(2) The Cabinet for Health and Family Services shall***:***

(a) Prepare a state child health plan***, known as KCHIP,*** meeting the requirements of Title XXI of the Federal Social Security Act, for submission to the Secretary of the United States Department of Health and Human Services within such time as will permit the state to receive the maximum amounts of federal matching funds available under Title XXI***; and*** ~~[. The cabinet shall,]~~

(b) By administrative regulation promulgated in accordance with KRS Chapter 13A, establish the following:

1. ~~[(a)]~~ The eligibility criteria for children covered by ***KCHIP, which shall include a provision that*** ~~[the Kentucky Children's Health Insurance Program. However,]~~ no person eligible for services under Title XIX of the Social Security Act***,*** 42 U.S.C. ***secs.*** 1396 to 1396v, as amended, shall be eligible for services under ***KCHIP,*** ~~[the Kentucky Children's Health Insurance Program]~~ except to the extent that Title XIX coverage is expanded by KRS 205.6481 to 205.6495 and KRS 304.17A-340;

2. ~~[(b)]~~ The schedule of benefits to be covered by ***KCHIP*** ~~[the Kentucky Children's Health Insurance Program]~~, which shall***:*** ~~[include preventive services, vision services including glasses, and dental services including at least sealants, extractions, and fillings, and which shall]~~

a. Be at least equivalent to one (1) of the following:

i. ~~[1.]~~ The standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefit Plan established by ***5*** U.S.C. sec. 8903(1);

ii. ~~[2.]~~A mid-range health benefit coverage plan that is offered and

generally available to state employees; or

iii.~~[3.]~~ Health insurance coverage offered by a health maintenance organization that has the largest insured commercial, non-Medicaid enrollment of covered lives in the state; ***and***

b. Comply with subsection (6) of this section;

3.~~[(c)]~~ The premium contribution per family ***for***~~[of]~~ health insurance coverage available under the ***KCHIP, which***~~[Kentucky Children's Health Insurance Program with provisions for the payment of premium contributions by families of children eligible for coverage by the program based upon a sliding scale relating to family income. Premium contributions]~~ shall be based***:***

a. On a six (6) month period***; and***

b. Upon a sliding scale relating to family income not to exceed:

i.~~[1.]~~ Ten dollars ($10), to be paid by a family with income between one hundred percent (100%) to one hundred thirty-three percent (133%) of the federal poverty level;

ii.~~[2.]~~Twenty dollars ($20), to be paid by a family with income between one hundred thirty-four percent (134%) to one hundred forty-nine percent (149%) of the federal poverty level; and

iii.~~[3.]~~ One hundred twenty dollars ($120), to be paid by a family with income between one hundred fifty percent (150%) to two hundred percent (200%) of the federal poverty level, and which may be made on a partial payment plan of twenty dollars ($20) per month or sixty dollars ($60) per quarter;

4.~~[(d)]~~ There shall be no copayments for services provided under

KCHIP~~[the Kentucky Children's Health Insurance Program]~~; and

5.~~[(e)]~~ ***a.*** The criteria for health services providers and insurers wishing to contract with the Commonwealth to provide~~[the children's health insurance]~~ coverage ***under KCHIP***.

b. ~~[However,]~~The cabinet shall provide, in any contracting process for ***coverage of***~~[the]~~ preventive ***services***~~[health insurance program]~~, the opportunity for a public health department to bid on preventive health services to eligible children within the public health department's service area. A public health department shall not be disqualified from bidding because the department does not currently offer all the services required by~~[paragraph (b) of]~~ this ***section***~~[subsection]~~. The criteria shall be set forth in administrative regulations under KRS Chapter 13A and shall maximize competition among the providers and insurers. The~~[Cabinet for]~~ Finance and Administration ***Cabinet*** shall provide oversight over contracting policies and procedures to assure that the number of applicants for contracts is maximized.

(3)~~[(2)]~~ Within twelve (12) months of federal approval of the state's Title XXI child health plan, the Cabinet for Health and Family Services shall assure that a KCHIP program is available to all eligible children in all regions of the state. If necessary, in order to meet this assurance, the cabinet shall institute its own program.

(4)~~[(3)]~~ KCHIP recipients shall have direct access without a referral from any gatekeeper primary care provider to dentists for covered primary dental services and to optometrists and ophthalmologists for covered primary eye and vision services.

(5)~~[(4)]~~ ***KCHIP***~~[The Kentucky Children's Health Insurance Plan]~~ shall comply with KRS 304.17A-163 and 304.17A-1631.

(6) The schedule of benefits required under subsection (2)(b)2. of this section shall

include:

(a) Preventive services;

(b) Vision services, including glasses;

(c) Dental services, including sealants, extractions, and fillings; and

(d) The coverage required under Section 5 of this Act.

➔SECTION 13. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Breast pump kit" means a collection of tubing, valves, flanges, bottles, and other parts required to extract human milk using a breast pump;

(b) "Lactation consultation" means the provision of lactation care and services by a qualified lactation support professional, including:

1. Lactation assessment;

2. Creation of a lactation care plan;

3. Lactation education; and

4. Recommendations for and instruction in the use of assistive devices;

(c) "Lactation counseling" means the provision of breastfeeding education and support services by a qualified lactation support professional or other licensed health care provider, including:

1. Providing a lactation assessment;

2. Creating a lactation care plan;

3. Providing lactation education, including educating women and families on the health impacts of breastfeeding and human lactation;

4. Advocating for breastfeeding as the norm for feeding infants and young children;

5. Providing breastfeeding support, encouragement, and care to help women and families meet their breastfeeding goals; and

6. Identifying and, when appropriate, referring high-risk mothers for clinical treatment; and

(d) "Qualified lactation support professional" means an individual who holds a current certification from a certification program accredited by the:

1. National Commission for Certifying Agencies;

2. Institute for Credentialing Excellence; or

3. American National Standards Institute.

(2) The Department for Medicaid Services and any managed care organization with which the department contracts for the delivery of Medicaid services shall provide coverage for comprehensive lactation counseling, lactation consultation, and breastfeeding equipment.

(3) The coverage required by this section shall:

(a) Not be subject to:

1. Any cost-sharing requirements, including but not limited to copayments; or

2. Utilization management requirements, including but not limited to prior authorization, prescription, or referral, except as permitted in paragraph (d) of this subsection;

(b) Be provided in conjunction with each birth for the duration of breastfeeding, as defined by the beneficiary;

(c) For lactation counseling and lactation consultation, include:

1. In-person, one-on-one counseling or consultation, including home visits, regardless of location of service provision;

2. The delivery of counseling or consultation via telehealth, as defined in KRS 205.510, if the beneficiary requests telehealth counseling or consultation in lieu of in-person, one-on-one counseling or consultation; or

3. Group counseling, if the beneficiary requests group counseling in lieu of in-person, one-on-one counseling or consultation; and

(d) For breastfeeding equipment, include:

1. Purchase of a single-user, double electric breast pump, or a manual pump in lieu of a double electric breast pump, if requested by the beneficiary;

2. Rental of a multi-user breast pump on the recommendation of a licensed health care provider; and

3. Two (2) breast pump kits as well as appropriately sized breast pump flanges and other lactation accessories recommended by a health care provider.

(4) (a) The breastfeeding equipment described in subsection (3)(d) of this section shall be furnished within forty-eight (48) hours of notification of need, if requested after the birth of the child, or by the later of two (2) weeks before the beneficiary's expected due date or seventy-two (72) hours after notification of need, if requested prior to the birth of the child.

(b) If the department cannot ensure delivery of breastfeeding equipment in accordance with paragraph (a) of this subsection, an individual may purchase equipment and the department or a managed care organization with whom the department contracts for the delivery of Medicaid services shall reimburse the individual for all out-of-pocket expenses incurred by the individual, including any balance billing amounts.

➔Section 14. If the state would, or would likely, be required to make payments to defray the cost of any requirement under Section 4 or 5 of this Act, as provided under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the Department of Insurance shall, within 90 days of the effective date of this section, apply for a waiver under 42 U.S.C. sec. 18052, as amended, or any other applicable federal law of all or any of the

cost defrayal requirements.

➔Section 15. If the Cabinet for Health and Family Services determines that a waiver or other authorization from a federal agency is necessary to implement Section 9, 10, 11, 12, or 13 of this Act for any reason, including the loss of federal funds, the cabinet shall, within 90 days of the effective date of this section, request the waiver or authorization, and may only delay implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 16. The Cabinet for Heath and Family Services shall study existing doula certification programs in the United States and currently operating doula services in the Commonwealth of Kentucky. The study shall review the training and quality requirements of doula certifications and consider potential recommendations regarding doula services for populations most at risk for poor perinatal outcomes. The Cabinet for Heath and Family Services may receive input from parties concerned with this study. The Cabinet for Heath and Family Services shall provide a report on the study to the Interim Joint Committee on Health Services by December 1, 2024. As used in this section, "doula services" means services provided by a trained nonmedical professional to support women and families throughout labor and birth, and intermittently during the prenatal and postpartum periods.

➔Section 17. Sections 4 to 9 of this Act apply to plans issued or renewed on or after January 1, 2025.

➔Section 18. Sections 4, 5, 6, 7, 8, 9, and 17 of this Act take effect on January 1, 2025.