CHAPTER 1

(HB 1)

AN ACT relating to compensation, including benefits, for public employees and officers, making an appropriation therefor, and declaring an emergency.

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

Section 1. The General Assembly finds and declares that:

(1) The contracts for the policies for group health care coverage provided pursuant to KRS 18A.225 for the period January 1, 2005, through December 31, 2005, were negotiated under a spending plan developed by the Governor, in the absence of a specific appropriation by the General Assembly;

(2) The health plans proposed for public employees are detrimental to the morale of public employees and harm the Commonwealth's ability to attract and retain qualified employees;

(3) The Governor issued a proclamation on October 4, 2004, convening the General Assembly for the sole purpose of considering the compensation, health insurance benefits, and retirement benefits of active and retired public employees, and to make an appropriation therefor; and

(4) It is in the best interest of the Commonwealth to modify or replace the contracts for health care for the period January 1, 2005, to December 31, 2005, in order to provide adequate and affordable health coverage for employees of the Commonwealth.

Section 2. Notwithstanding KRS 18A.225, 45A.022, 45A.080, 45A.085, 45A.090, 45A.225 to 45A.290, or any other provision of KRS Chapter 45A to the contrary, retroactive to August 12, 2004, the Finance and Administration Cabinet shall implement the provisions of this Act by amending the previously negotiated contracts for public employee health insurance. The secretary of the Finance and Administration Cabinet shall provide an actuarial certification that the self-insured contract amounts are actuarially sound. Any contracts entered into or modified pursuant to this section shall be forwarded to the Legislative Research Commission.

Section 3. For the period January 1, 2005, through December 31, 2005, the policy or policies for group health care coverage provided pursuant to KRS 18A.225 shall contain three health plans which shall be named "Commonwealth Essential," "Commonwealth Enhanced," and "Commonwealth Premier." The benefits described in this section shall be incorporated into the contracts pursuant to Section 2 of this Act for the policies and shall be reflected in the certificates of coverage issued in compliance with KRS Chapter 304.

(1) For purposes of this section, “cost” means an eligible expense which:

  (a) Is the provider’s usual charge for a given service under the covered person’s plan; and

  (b) is within the range of fees charged by providers of similar training and experience for the same or similar service or supply within the same or similar geographic area; and

  (c) does not exceed the fee schedule developed by the carrier for a network provider.

(2) The benefits provided under the Commonwealth Essential plan shall be as follows:

  (a) Outpatient services, which shall include physician or mental health provider office visits; diagnostic and allergy testing, allergy serum and injections; diabetes education and therapy; injections; lab fees; X-rays; and mental health or chemical dependency services.

    1. The member's cost for the services within the provider network shall be no more than 25% of the cost per visit after meeting the deductible.

    2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible.

    3. The member's cost shall include all services performed on the same day at the same site;

  (b) Care in a hospital, which shall include coverage for provider services; inpatient care; semi-private room; transplant coverage, including kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas; and mental health and chemical dependence services.

1. The member's cost for the services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(c) Diagnostic testing, which shall include laboratory tests; X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury.

1. The member's cost for the services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible.

3. The member's cost shall include all services performed on the same day at the same site. Diagnostic testing performed in a physician’s office in conjunction with an office visit shall be included in the member's cost under paragraph (a) of this subsection for the office visit;

(d) Ambulatory hospital and outpatient surgery services, which shall include outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician’s office.

1. The member's cost for the services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(e) Preventative care, which shall include an annual gynecological exam, well child care, routine physical, and early detection tests subject to age and periodicity limits. Preventative care shall be paid at 100% by the plan up to a maximum of $200 per covered individual in services during a calendar year. The plan shall pay 100% of eligible immunizations;

(f) Emergency services, which shall include emergency room treatment, emergency room physician charges, urgent care center treatment, and ambulance services resulting from an emergency medical condition as defined in KRS 304.17A-500, and shall also include emergency screening and stabilization services.

1. The member's cost for emergency room treatment and emergency room physician charges within the provider network resulting from an emergency medical condition shall be $50 plus 25% of the cost after meeting the deductible. If the member is admitted to the hospital, the $50 copayment shall be waived.

2. For emergency room treatment and emergency room physician charges outside the provider network resulting from an emergency medical condition, the plan shall pay at least 50% of the cost after the member has paid $50 and has met the deductible. If the member is admitted to the hospital, the $50 copayment shall be waived.

3. The member’s cost for urgent care and ambulance services within the provider network shall be no more than 25% of the cost after meeting the deductible.

4. For urgent care and ambulance services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(g) Maternity care, which shall include prenatal care; labor; delivery; postpartum care; and one ultrasound per pregnancy. Additional ultrasounds shall be covered with prior plan approval.

1. The member's cost for office visits within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. The member's cost for in-hospital care within the provider network shall be no more than 25% of the cost after meeting the deductible.

3. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(h) Prescription drugs, which shall include drugs purchased from a retail pharmacy and through the mail-order program.

1. The member's cost per 30-day supply from a retail pharmacy within the provider network shall be 25% of the cost, except as follows:

a. Generic drugs shall have a minimum copayment that is the lesser of the cost of the prescription or $10 and a maximum copayment of $25;

b. Preferred brand drugs shall have a minimum copayment that is the lesser of the cost of the prescription or $20 and a maximum copayment of $50; and

c. Nonpreferred brand drugs shall have a minimum copayment that is the lesser of the cost of the prescription or $35 and a maximum copayment of $100.

2. The member's cost per 90-day supply from the provider's mail-order supplier shall be 25% of the cost, except that the minimum and maximum copayments shall be equal to twice the amount determined under subparagraph 1. of this paragraph;

(i) Audiometric services, which shall only be covered in conjunction with a disease, illness, or injury.

1. The member's cost for services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(j) Chiropractic services, which shall include up to 26 office visits per year, with no more than one visit per day.

1. The member's cost for the office visits within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For office visits outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(k) Autism services, which shall include rehabilitative care, therapeutic care, and respite care for children ages two through 21, up to a maximum of $500 per month.

1. The member's cost for rehabilitative and therapeutic care services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For rehabilitative and therapeutic services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible.

3. For respite care, within the provider network, the plan shall pay 75% of the cost after the member has met the deductible.

4. For respite care outside the provider network, the plan shall pay 50% of the cost after the member has met the deductible;

(l) Hospice care, which shall be subject to precertification by the plan and shall be covered the same as under the federal Medicare program;

(m) Other covered services, which shall include durable medical equipment, prosthetic devices, home health limited to 60 visits per year, physical therapy limited to 30 visits per year, occupational therapy limited to 30 visits per year, cardiac rehabilitation therapy limited to 30 visits per year, speech therapy limited to 30 visits per year, and skilled nursing facility services limited to 30 days per year.

1. The member's cost for services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(n) Hearing aids, which shall be for covered individuals under 18 years of age and limited to one per ear every three years and a maximum benefit of $1,400 per ear.

1. The member's cost for services within the provider network shall be no more than 25% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(o) The deductible applicable to services under this subsection shall be as follows:

1. For costs incurred within the provider network, $750 per year for each covered individual limited to a maximum of $1,500 per year for all individuals of a family covered under the same contract;

2. For costs incurred outside the provider network, $1,500 per year for each covered individual limited to a maximum of $3,000 per year for all individuals of a family covered under the same contract; and

3. The member's costs incurred for services within the provider network shall be counted toward the out-of-network deductible. The member's costs incurred for services outside the provider network shall be counted toward the in-network deductible;

(p) With the exception of prescription drug expenses and emergency room copayments, the plan shall pay 100% of the cost of covered services after a member has paid:

1. For services within the provider network, a total of $3,500 per covered individual limited to a maximum of $7,000 for all individuals of a family covered under the same contract; and

2. For services outside the provider network, a total of $7,000 per covered individual limited to a maximum of $14,000 for all individuals of a family covered under the same contract.

The total annual costs for services within the provider network shall be included to determine whether the member meets the total annual costs requirement for services outside the provider network. The total annual costs for services outside the provider network shall be included to determine whether the member meets the total annual cost requirement for services within the provider network; and

(q) There shall be no limit to the amount of covered services over a member's lifetime.

(3) The benefits provided under the Commonwealth Enhanced plan shall be as follows:

(a) Outpatient services, which shall include physician or mental health provider office visits; diagnostic and allergy testing; allergy serum and injections; diabetes education and therapy; well child care; immunizations; injections; lab fees; X-rays; and mental health or chemical dependency services.

1. The member's cost for the services within the provider network shall be $10 per visit.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible.

3. The member's cost shall include all services performed on the same day at the same site;

(b) Care in a hospital, which shall include coverage for provider services; inpatient care; semi-private room; transplant coverage, including kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas; and mental health and chemical dependence services.

1. The member's cost for the services within the provider network shall be no more than 20% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(c) Outpatient diagnostic testing, which shall include laboratory tests; X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury.

1. The member's cost for the services within the provider network shall be no more than $10 per visit.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible.

3. The member's cost shall include all services performed on the same day at the same site. Diagnostic testing performed in a physician's office in conjunction with an office visit shall be included in the member's cost under paragraph (a) of this subsection for the office visit;

(d) Ambulatory hospital and outpatient surgery services, which shall include outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.

1. The member's cost for the services within the provider network shall be no more than 20% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(e) Preventative care, which shall include an annual gynecological exam, routine physical, and early detection tests, subject to age and periodicity limits. There shall be a maximum benefit of $400 in preventative services per covered individual each plan year.

1. The member's cost for the services within the provider network shall be a $10 copayment per office visit.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(f) Emergency services, which shall include emergency room treatment, and emergency room physician charges resulting from an emergency medical condition as defined in KRS 304.17A-500, and shall also include emergency screening and stabilization services.

1. The member's cost for emergency room services within the provider network resulting from an emergency medical condition shall be $50 plus 20% of the cost. If the member is admitted to the hospital, the $50 copayment shall be waived;

2. For emergency room treatment and emergency room physician charges outside the provider network resulting from an emergency medical condition, the plan shall pay at least 60% of the cost after the member has paid $50. If the member is admitted to the hospital, the $50 copayment shall be waived.

(g) Urgent care center treatment, which shall include treatment at a facility for urgent care other than a hospital.

1. The member's cost for urgent care center treatment within the provider network shall be $20.

2. For urgent care center treatment outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(h) Ambulance services.

1. The member's cost for ambulance services within the provider network shall be no more than 20% of the cost after meeting the deductible.

2. For ambulance services outside the provider network, the plan shall pay at least 80% of the cost after the member has met the deductible;

(i) Maternity care, which shall include prenatal care; labor; delivery; postpartum care; and one ultrasound per pregnancy. Additional ultrasounds are covered with prior plan approval.

1. The member's cost for office visits within the provider network shall be $10, limited to the office visit in which pregnancy is diagnosed. Thereafter, there shall be no copayment required.

2. The member's cost for in-hospital care within the provider network shall be no more than 20% of the cost after meeting the deductible.

3. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(j) Prescription drugs, which shall include drugs purchased from a retail pharmacy and through the mail-order program.

1. The member's cost per 30-day supply from a retail pharmacy within the provider's network shall be the lesser of the actual cost or $10 per generic prescription, $15 per preferred brand prescription, and $30 per nonpreferred brand prescription.

2. The retail pharmacy copayments shall be reduced to $5 per generic prescription, $10 per preferred brand prescription, and $20 per nonpreferred brand prescription after the 75th retail prescription for all individuals covered under the same contract.

3. For prescription drugs received from a pharmacy outside the provider network, the plan shall pay 60% of the cost.

4. The member's cost per 90-day supply from the provider's mail-order supplier shall be equal to twice the amount determined under subparagraph 1. of this paragraph;

(k) Audiometric services, which shall only be covered in conjunction with a disease, illness, or injury.

1. The member's cost for services within the provider network shall be no more than 50% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(l) Chiropractic services, which shall include up to 26 office visits per year, with no more than one visit per day.

1. The member's cost for the office visits within the provider network shall be $10 per visit.

2. For office visits outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(m) Autism services, which shall include rehabilitative care, therapeutic care, and respite care for children ages two through 21, up to a maximum benefit of $500 per month.

1. The member's cost for rehabilitative and therapeutic services within the provider network shall be no more than $10 per visit.

2. For rehabilitative and therapeutic services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible.

3. For respite care within the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible.

4. For respite care outside the provider network, the plan shall pay at least 50% of the cost after the member has met the deductible;

(n) Hospice care, which shall be subject to precertification by the plan and shall be covered the same as under the federal Medicare program;

(o) Hearing aids, which shall be for covered individuals under 18 years of age and limited to one per ear every three years and a maximum benefit of $1,400 per ear.

1. The member’s cost for services within the provider network shall be no more than 20% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(p) Other covered services, which shall include durable medical equipment, prosthetic devices, home health limited to 60 visits per year, physical therapy limited to 30 visits per year, occupational therapy limited to 30 visits per year, cardiac rehabilitation therapy limited to 30 visits per year, speech therapy limited to 30 visits per year, and skilled nursing facility services limited to 30 days per year.

1. The member's cost for services within the provider network shall be no more than 20% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 60% of the cost after the member has met the deductible;

(q) The deductible applicable to services under this subsection, other than services received in a physician's office, preventative care services, outpatient diagnostic testing, urgent care center treatment, prescription drugs, chiropractic services, and hospital emergency room services, shall be as follows:

1. For costs incurred within the provider network, $250 per year for each covered individual limited to a maximum of $500 per year for all individuals of a family covered under the same contract;

2. For costs incurred outside the provider network, $500 per year for each covered individual limited to a maximum of $1,000 per year for all individuals of a family covered under the same contract;

3. The member's costs incurred for services within the provider network shall be counted toward the out-of-network deductible. The member's costs incurred for services outside the provider network shall be counted toward the in-network deductible;

(r) With the exception of copayments for prescription drugs, office visits, hospital emergency room visits, and urgent care center services, the plan shall pay 100% of covered expenses after the member has paid:

1. For services within the provider network, a total of $1,250 per covered individual limited to a maximum of $2,500 for all individuals in a family covered under the same contract; and

2. For services outside the provider network, a total of $2,500 per covered individual limited to a maximum of $5,000 for all individuals in a family covered under the same contract.

The total annual costs for services within the provider network shall be included to determine whether the member meets the total annual costs requirement for services outside the provider network. The total annual costs for services outside the provider network shall be included to determine whether the member meets the total annual cost requirement for services within the provider network; and

(s) There shall be no limit to the amount of covered services over a member's lifetime.

(4) The benefits provided under the Commonwealth Premier plan shall be as follows:

(a) Outpatient services, which shall include physician or mental health provider office visits; diagnostic and allergy testing; allergy serum and injections; diabetes education and therapy; well child care; immunizations; injections; lab fees; X-rays; and mental health or chemical dependency services.

1. The member's cost for the services within the provider network shall be $10 per visit.

2. For services outside the provider's network, the plan shall pay at least 70% of the cost after the member has met the deductible.

3. The member's cost shall include all services performed on the same day at the same site;

(b) Care in a hospital, which shall include coverage for provider services; inpatient care; semi-private room; transplant coverage, including kidneys, cornea, bone marrow, heart, liver, lungs, heart and lung, and pancreas; and mental health and chemical dependence services.

1. The member's cost for the services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(c) Outpatient diagnostic testing, which shall include laboratory tests; X-rays and other radiology or imaging services; and ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury.

1. The member's cost for the services within the provider network shall be $10 per visit.

2. For services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible.

3. The member's cost shall include all services performed on the same day at the same site. Diagnostic testing performed in a physician's office in conjunction with an office visit shall be included in the member's cost under paragraph (a) of this subsection for the office visit;

(d) Ambulatory hospital and outpatient surgery services, which shall include outpatient surgery services, including biopsies, radiation therapy, renal dialysis, chemotherapy, and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center other than a physician's office.

1. The member's cost for the services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For the services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(e) Preventative care, which shall include an annual gynecological exam, routine physical, and early detection tests, subject to age and periodicity limits. There shall be a maximum benefit of $400 in preventative services per covered individual each plan year.

1. The member's cost for the services within the provider network shall be a $10 copayment per office visit.

2. For services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(f) Emergency services, which shall include emergency room treatment, and emergency room physician charges resulting from an emergency medical condition as defined in KRS 304.17A-500, and shall also include emergency screening and stabilization services.

1. The member's cost for emergency room treatment within the provider network resulting from an emergency medical condition shall be $50 plus 10% of the cost. If the member is admitted to the hospital, the $50 copayment shall be waived.

2. For emergency room treatment and emergency room physician charges outside the provider network resulting from an emergency medical condition, the plan shall pay at least 70% of the cost after the member has paid $50 and has met the deductible. If the member is admitted to the hospital, the $50 copayment shall be waived;

(g) Urgent care center treatment, which shall include treatment at a facility for urgent care other than a hospital.

1. The member's cost for urgent care center treatment within the provider network shall be $20.

2. For urgent care center treatment outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(h) Ambulance services.

1. The member's cost for ambulance services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For ambulance services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(i) Maternity care, which shall include prenatal care; labor; delivery; postpartum care; and one ultrasound per pregnancy. Additional ultrasounds are covered with prior plan approval.

1. The member's cost for office visits within the provider network shall be $10 per visit, limited to the office visit in which pregnancy is diagnosed. Thereafter, there shall be no copayment required.

2. The member's cost for in-hospital care within the provider network shall be no more than 10% of the cost after meeting the deductible.

3. For all the services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(j) Prescription drugs, which shall include drugs purchased from a retail pharmacy and through the mail-order program.

1. The member's cost per 30-day supply from a retail pharmacy within the provider network shall be the lesser of the actual cost or $10 per generic prescription, $15 per preferred brand prescription, and $30 per nonpreferred brand prescription.

2. The retail pharmacy copayments shall be reduced to $5 per generic prescription, $10 per preferred brand prescription, and $20 per nonpreferred brand prescription after the 75th retail prescription for all individuals covered under the same contract.

3. For prescription drugs received from a pharmacy outside the provider network, the plan shall pay 70% of the cost.

4. The member's cost per 90-day supply from the provider's mail-order supplier shall be equal to twice the amount determined under subparagraph 1. of this paragraph;

(k) Audiometric services, which shall only be covered in conjunction with a disease, illness, or injury.

1. The member's cost for services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For member services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(l) Chiropractic services, which shall include up to 26 office visits per year with no more than one visit per day.

1. The member's cost for the office visits within the provider network shall be $10 per visit.

2. For office visits outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(m) Autism services, which shall include rehabilitative care, therapeutic care, and respite care for children ages two through 21, up to a maximum benefit of $500 per month.

1. The member's cost for rehabilitative and therapeutic services within the provider network shall be $10 per visit.

2. For rehabilitative and therapeutic services outside the provider network, the plan shall pay at least 70% of the cost after the employee has met the deductible.

3. For respite care within the provider network, the plan shall pay at least 90% of the cost after the member has met the deductible.

4. For respite care outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(n) Hospice care, which shall be subject to precertification by the plan and shall be covered the same as under the federal Medicare program;

(o) Hearing aids, which shall be for covered individuals under 18 years of age and limited to one per ear every three years and a maximum benefit of $1,400 per ear.

1. The member’s cost for services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(p) Other covered services, which shall include durable medical equipment, prosthetic devices, home health limited to 60 visits per year, physical therapy limited to 30 visits per year, occupational therapy limited to 30 visits per year, cardiac rehabilitation therapy limited to 30 visits per year, speech therapy limited to 30 visits per year, and skilled nursing facility services limited to 30 days per year.

1. The member's cost for services within the provider network shall be no more than 10% of the cost after meeting the deductible.

2. For services outside the provider network, the plan shall pay at least 70% of the cost after the member has met the deductible;

(q) The deductible applicable to services under this subsection, other than services received in a physician's office, preventative care services, outpatient diagnostic testing, urgent care center treatment, prescription drugs, chiropractic services, and hospital emergency room services, shall be as follows:

1. For costs incurred within the provider network, $250 per year for each covered individual limited to a maximum of $500 per year for all individuals in a family covered under the same contract;

2. For costs incurred outside the provider network, $500 per year for each covered individual limited to a maximum of $1,000 per year for all individuals in a family covered under the same contract; and

3. The member's costs incurred for services within the provider network shall be counted toward the out-of-network deductible. The member's costs incurred for services outside the provider's network shall be counted toward the in-network deductible;

(r) With the exception of copayments for prescription drugs, office visits, hospital emergency room visits, and urgent care center services, the plan shall pay 100% of covered expenses after the member has paid:

1. For services within the provider network, a total of $1,000 per covered individual limited to a maximum of $2,000 for all individuals in a family covered under the same contract; and

2. For services outside the provider network, a total of $2,000 per covered individual limited to a maximum of $4,000 for all individuals in a family covered under the same contract.

The total annual costs for services within the provider network shall be included to determine whether the member meets the total annual costs requirement for services outside the provider network. The total annual costs for services outside the provider network shall be included to determine whether the member meets the total annual cost requirement for services within the provider network; and

(s) There shall be no limit to the amount of covered services over an member's lifetime.

(4) The provider networks for a geographic region shall be substantially similar to the networks available in that geographic region under the policy or policies for the state health insurance plan for the period January 1, 2004, through December 31, 2004.

Section 4. (1) For the period January 1, 2005, through December 31, 2005, the employer contribution shall be the difference between the premium rate and the employee contribution set forth below.

(a) The monthly employee contribution for nonsmokers shall be as follows:

Level of Coverage	Commonwealth Essential	Commonwealth Enhanced	Commonwealth Premier
Single	Not offered	$0.00	$18.20
Parent Plus	$55.00	$114.00	$170.38
Couple	$259.53	$357.72	$398.67
Family	$320.14	$429.24	$474.74

(b) The monthly employee contribution for smokers shall be as follows:

Level of Coverage	Commonwealth Essential	Commonwealth Enhanced	Commonwealth Premier
Single	Not offered	$15.00	$33.20
Parent Plus	$85.00	$144.00	$200.38
Couple	$289.53	$387.72	$428.67
Family	$350.14	$459.24	$504.74

(2) In addition to one dependent subsidy contribution toward family coverage under subsection (1) of this section, the Personnel Cabinet shall permit married couples who are both eligible to participate in the state health insurance plan to be covered under one family health benefit plan and to apply each employer contribution for the single premium of the plan they select toward family coverage, not to exceed the total premium.

(3) Except as provided in KRS 18A.225(13), for employees of the state and employees of local school boards who are eligible to participate in the state health insurance program and who waive coverage under the program, the state shall contribute $234 per month to the employee's flexible spending account.

(4) A difference in employee contribution rates for smokers and nonsmokers under this plan shall not be deemed to be an unlawful practice in violation of KRS 344.040.

SECTION 5. A NEW SECTION OF KRS CHAPTER 18A IS CREATED TO READ AS FOLLOWS:

(1) The secretary of the Personnel Cabinet shall submit to the Advisory Committee of State Health Insurance Subscribers established in KRS 18A.225, at least thirty (30) days prior to issuing requests for proposals, the health benefit plans that will be submitted to carriers. The secretary of the Personnel Cabinet shall also provide to employee organizations who are represented on the Advisory Committee of State Health Insurance Subscribers information necessary so that the member representing the organization can fulfill his or her responsibilities under this section. The advisory committee shall submit in writing to the secretary the committee's approval of the plans or its recommendations on changes to the plans no later than seven (7) days prior to the issuance of requests for proposals. The advisory committee shall advise the secretary on:

(a) Health insurance benefit options that should be included in the program;

(b) Procedures for soliciting bids or requesting proposals for contracts from carriers for the program;

(c) The implementation, maintenance, and administration of the health insurance benefits under the program; and

(d) The development of a uniform prescription drug formulary that contains fair and reasonable standards and procedures for patient access to medically necessary alternatives to the formulary and patient choice of higher-cost alternatives to the formulary, and that ensures that discounts negotiated with drug manufacturers are passed to the program.

(2) The secretary of the Personnel Cabinet shall, at the discretion of the co-chairs of the Interim Joint Committee on Appropriations and Revenue, either submit a written report to or testify before the Interim Joint Committee on Appropriations and Revenue on the state employee health insurance program for the next plan year prior to the issuance of the requests for proposals.

SECTION 6. A NEW SECTION OF KRS CHAPTER 18A IS CREATED TO READ AS FOLLOWS:

Employees who participate in a medical expense flexible spending account plan pursuant to KRS 18A.227 may carry forward to the succeeding plan year unused funds remaining in the flexible spending account at the end of the plan year to the extent that such carry forward is allowed by the Internal Revenue Code in effect on the date the plan year ends.

Section 7. (1) The Speaker of the House and the President of the Senate are directed to establish the Blue Ribbon Panel on Public Employee Health Benefits, a legislative branch task force, for the purpose of examining all aspects of health benefits available to public employees including the procurement process, benefits offered, plan membership, implementation, maintenance and administration of the plan; alternative methods of providing benefits and services, and any other issues related to public employee health benefits the panel determines to be relevant. The panel shall make recommendations and propose legislation in accordance with the provisions of subsections (3) and (4) of this section.

(2) The panel shall be composed of thirty-two (32) members as follows:

(a) Two (2) co-chairpersons, one (1) to be appointed by the Speaker of the House and one (1) to be appointed by the President of the Senate;

(b) The chairperson of the Advisory Committee of State Health Insurance Subscribers or the chairperson's appointed designee;

(c) Two (2) representatives from the executive branch, to be appointed by the Governor;

(d) Two (2) members of the Kentucky House of Representatives, one (1) to be appointed by the Speaker of the House, and one (1) to be appointed by the leader of the minority party;

(e) Two (2) members of the Kentucky Senate, one (1) to be appointed by the President of the Senate, and one (1) to be appointed by the leader of the minority party;

(f) One (1) representative from the Judicial Branch, to be appointed by the Chief Justice of the Supreme Court;

(g) Two (2) members from a list of five (5) representing active certified education employees and two (2) members from a list of five (5) representing retired certified education employees with the list to be submitted by the organization with the largest number of teacher members on payroll deduction, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(h) Two (2) members from a list of five (5) representing active classified education employees and two (2) members from a list of five (5) representing retired classified education employees with the list to be submitted by the organization with the largest number of classified members on payroll deduction, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(i) Two (2) members from a list of five (5) names submitted by the labor federation with the largest number of state employees, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(j) Two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(k) Two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(l) Two (2) members representing retired state employees, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(m) Two (2) members representing the insurance industry, one (1) each to be appointed by the Speaker of the House and the President of the Senate;

(n) Two (2) members representing health care providers, one (1) each to be appointed by the Speaker of the House and President of the Senate;

(o) One (1) representative of the Kentucky Retirement Systems, to be appointed by the chairperson of the Board of Trustees of the Kentucky Retirement Systems; and

(p) One (1) representative of the Kentucky Teachers' Retirement System, to be appointed by the chairperson of the Board of Trustees of the Kentucky Teachers' Retirement System.

Organizations or entities required to submit a list of names to the Speaker of the House and President of the Senate shall do so within thirty (30) days of the effective date of this Act. All appointments shall be made within forty-five (45) days of the effective date of this Act. The names of appointees shall be communicated to the Director of the Legislative Research Commission.

(3) The panel shall initially meet no later than January 15, 2005, and shall submit a written report and proposed legislation in accordance with subsection (4) of this section to the Legislative Research Commission, the Governor and the Chief Justice of the Supreme Court no later than April 30, 2005. The report and proposed legislation shall be presented to the Interim Joint Committees on Appropriations & Revenue and State Government during the 2005 interim. The panel shall cease to exist upon the delivery and presentation of its report and proposed legislation.

(4) The panel shall review health benefits available to public employees and shall make recommendations and propose legislation as necessary to address the following areas:

(a) The process for receiving input and providing oversight can be improved, including an examination of the composition, function, and duties of the Advisory Committee on State Health Insurance Subscribers established under KRS 18A.225(10) and the Group Health Insurance Board established under KRS 18A.226;

(b) The procurement process;

(c) Plan benefits, costs and premiums including dependent coverage, relative to surrounding states and the nation at large;

(d) Alternative benefits, programs and methods for providing coverage to public employees;

(e) Trends in health insurance and the consideration of various implications for the future; and

(f) Any other issues the panel identifies.

(5) The panel may employ consultants if approved by the Legislative Research Commission, request and hear testimony, and take other necessary steps to ensure a thorough study of the issue. The panel shall be staffed by the Legislative Research Commission.

(6) Except as provided in KRS 18A.200, members of the panel shall receive actual travel expenses while attending meetings.

(7) Provisions of this section to the contrary notwithstanding, the Legislative Research Commission shall have the authority to alternatively assign the issues identified herein to an interim joint committee or a subcommittee thereof, and to designate a study completion date.

Section 8. Each retired teacher eligible for the increase under KRS 161.620(2) shall receive:

(1) An additional cost-of-living increase of eight-tenths of one percent (.8%) that shall apply retroactively to July 1, 2004; and

(2) Effective July 1, 2005, an additional cost-of-living increase of seven-tenths of one percent (.7%).

Section 9. Notwithstanding KRS 61.565, the employer contribution rate for an entity participating in the Kentucky Employees Retirement System or State Police Retirement System shall be as follows:

(1) From July 1, 2004, through June 30, 2005, the contribution rates shall be no more than 5.89 percent for nonhazardous duty employees, 18.84 percent for hazardous duty employees, and 21.58 percent for employees of the State Police Retirement System. This provision shall be retroactive to July 1, 2004; and

(2) From July 1, 2005, through June 30, 2006, the employer contribution rate shall be no more than 5.89 percent for nonhazardous duty employees, 18.84 percent for hazardous duty employees, and 21.58 percent for employees of the State Police Retirement System.

Section 10. Notwithstanding KRS 18A.355(1):

(1) A cost-of-living adjustment of two percent is provided in fiscal year 2004-2005 on the base salary or wages of each eligible state employee on his or her anniversary date and shall apply retroactively to July 1, 2004; and

(2) Effective January 1, 2005, an additional cost-of-living adjustment of one percent is provided on the base salary or wages of each eligible state employee.

Section 11. Notwithstanding KRS 157.420(2), all certified and classified staff employed by local boards of education shall receive:

(1) A cost-of-living adjustment of not less than two percent in fiscal year 2004-2005 and shall apply retroactively to July 1, 2004; and

(2) Effective January 1, 2005, an additional cost-of-living adjustment of one percent is provided. The cost-of-living adjustments shall be in addition to the normal rank and experience increases attained by certified staff and in addition to any salary increase a classified employee might obtain due to additional experience or job classification.

Section 12. PERSONNEL CABINET. (1) There is hereby appropriated from the General Fund in fiscal year 2004-2005 $720,623,700 to the State Salary and Compensation Fund in the Personnel Cabinet. Included in this appropriation is $708,014,100 for the base salary and related fringe benefits, and $8,197,600 for a two percent cost-of-living adjustment on the employee's annual increment date for eligible state employees. Included in the above is $4,412,000 for a one percent cost-of-living adjustment to be granted to all eligible state employees effective January 1, 2005.

(2) There is hereby appropriated from the General Fund in fiscal year 2004-2005 $77,451,900 to the State Group Health Insurance Fund in the Personnel Cabinet. Included in this appropriation is $59,489,400 to cover the

base employer share of the cost of health insurance and flexible spending for eligible Executive Branch employees. Included in this appropriation is $15,371,000 to provide for additional health insurance benefits and flexible spending contributions as provided for in this Act. Included in this appropriation is $2,591,500 for the Personnel Cabinet to provide assistance to eligible quasi-governmental employers and the Kentucky Community and Technical College System for their employees participating in the state health insurance program for the employer cost of increased benefits to the plan resulting from this Act. The funds will be distributed to eligible employers based on each employer's proportion of the total eligible participants in the state health insurance program.

(3) The Secretary of the Personnel Cabinet, in consultation with the State Budget Director, shall determine, in a manner consistent with the provisions of this Act, the amount of funds necessary by budget unit to provide for the salary and related expenses and health insurance benefits. The State Salary and Compensation Fund and the State Group Health Insurance Fund shall be supplemented to the maximum extent possible by Restricted Funds, Federal Funds, the Road Fund and other General Funds.

(4) The Secretary of the Personnel Cabinet, upon approval by the State Budget Director, shall notify the Secretary of the Finance and Administration Cabinet of the respective amount of General Fund from the State Salary Compensation Fund and the State Group Health Insurance Fund to be transferred to each affected budget unit, and such funds shall be transferred. The Secretary of the Personnel Cabinet and the State Budget Director shall report to the Interim Joint Committee on Appropriations and Revenue regarding the implementation of this provision on a timely basis.

Section 13. DEPARTMENT OF EDUCATION. (1) There is hereby appropriated from the General Fund to the Department of Education $2,428,801,400 in fiscal year 2004-2005 for the Support Education Excellence in Kentucky program. Included in this appropriation is $2,387,759,500 for the baseline Support Education Excellence in Kentucky and related programs in fiscal year 2004-2005. Included in the total appropriation is $36,600,000 for the cost-of-living increase for certified and classified employees of local boards of education as provided in this Act. Also included in the total appropriation is $4,441,900 to support the Kentucky Teachers' Retirement System contributions for associated salary increases for active members. Notwithstanding any statute to the contrary, the Commissioner of Education, in consultation with the State Budget Director, shall determine the amounts to be allocated to local school districts and to various programs funded within the Support Education Excellence in Kentucky appropriation unit.

(2) There is also appropriated from the General Fund to the Department of Education $363,670,600 in fiscal year 2004-2005 for employer contributions for health insurance and the contribution to the flexible spending account for employees waiving coverage. Included in this appropriation is $304,102,600 for baseline employer contributions for health insurance and the contribution to the flexible spending account for employees waiving coverage. Included in the total appropriation is $59,568,000 to provide for the additional health insurance benefits and flexible spending contributions as provided in this Act. If the costs for health insurance for employees of local school districts exceed the level of appropriated funds, the Governor is authorized to expend available General Fund moneys to fulfill this provision.

Section 14. KENTUCKY TEACHERS' RETIREMENT SYSTEM. To carry out the provisions of this Act, there is appropriated from the General Fund to the Kentucky Teachers' Retirement System $3,996,200 for fiscal year 2004-2005 and $7,706,900 for fiscal year 2005-2006 to provide the cost-of-living increase. In addition, there is appropriated from the General Fund $2,228,000 for fiscal year 2004-2005 for an additional subsidy for retired teachers who choose couple, family, or parent-plus coverage.

Section 15. KENTUCKY RETIREMENT SYSTEMS. To carry out the provisions of this Act, there is appropriated from the General Fund to the Kentucky Retirement Systems $4,562,500 for fiscal year 2004-2005 to provide a subsidy for retired members who choose couple, family, or parent-plus coverage.

Section 16. JUDICIAL BRANCH. There is hereby appropriated from the General Fund to the Judicial Branch $1,760,900 in fiscal year 2004-2005 and $3,521,800 in fiscal year 2005-2006 for health insurance. This is in addition to the amounts appropriated in House Bill 396 of the 2004 Regular Session of the General Assembly. There is also appropriated from the General Fund to the Judicial Branch $239,200 in fiscal year 2004-2005 and $239,200 in fiscal year 2005-2006 to provide an additional cost-of-living adjustment effective January 1, 2005.

Section 17. LEGISLATIVE BRANCH. There is hereby appropriated from the General Fund to the Legislative Branch $323,000 in fiscal year 2004-2005 and $646,000 in fiscal year 2005-2006 for health insurance. This is in addition to the amounts appropriated in House Bill 397 of the 2004 Regular Session of the General Assembly.

Section 18. The Personnel Cabinet shall not enter into any new contracts required under KRS 78.530 for coverage of employees in the state health plan from the effective date of this Act through December 31, 2005.

Section 19. The provisions of this Act shall be effective, KRS 6.350 to the contrary notwithstanding.

Section 20. In order to implement the changes to the state group health insurance plan effective January 1, 2005, an emergency is declared to exist, and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.

Section 21. Notwithstanding KRS 6.190 or 6.211, no member of the General Assembly shall be paid under KRS 6.190 or 6.211 for any day when the General Assembly is in recess for more than two legislative days, during the 2004 first extraordinary legislative session.

Approved October 19, 2004