CHAPTER 67

(HB 140)

AN ACT relating to telehealth.

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:

As used in Sections 1 to 4 of this Act, unless context otherwise requires:

(1) "Cabinet" means the Cabinet for Health and Family Services;

(2) "Health care service" means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed or certified and includes physical and behavioral health care;

(3) "Professional licensure board" means a licensure board established in Kentucky for the purpose of regulating and overseeing the practice of health care providers, including but not limited to:

(a) Board of Physical Therapy as established in KRS 327.030;

(b) Kentucky Applied Behavior Analysis Licensing Board as established in KRS 319C.030;

(c) Kentucky Board of Alcohol and Drug Counselors established by KRS 309.081;

(d) Kentucky State Board of Chiropractic Examiners established by KRS 312.025;

(e) Kentucky Board of Dentistry established by KRS 313.020;

(f) Kentucky Board of Emergency Medical Services established by KRS 311A.015;

(g) Kentucky Board of Examiners of Psychology established by KRS 319.020;

(h) Kentucky Board of Licensed Diabetes Educators established by KRS 309.329;

(i) Kentucky Board of Licensed Professional Counselors established by KRS 335.510;

(j) Kentucky Board of Licensure and Certification for Dietitians and Nutritionists established by KRS 310.040;

(k) Kentucky Board of Licensure for Marriage and Family Therapists established by KRS 335.310;

(l) Kentucky Board of Licensure for Occupational Therapy established by KRS 319A.020;

(m) Kentucky Board of Licensure for Professional Art Therapists established by KRS 309.131;

(n) State Board of Medical Licensure established by KRS 311.530;

(o) Kentucky Board of Nursing established by KRS 314.121;

(p) Kentucky Board of Optometric Examiners established by KRS 320.230;

(q) Kentucky Board of Pharmacy established by KRS 315.150;

(r) Kentucky Board of Social Work established by KRS 335.050;

(s) Kentucky Board of Respiratory Care established by KRS 314A.200; and

(t) Kentucky Board of Speech-Language Pathology and Audiology established by KRS 334A.070;

(4) "State agency authorized or required to promulgate administrative regulations relating to telehealth" means:

(a) A professional licensure board;

(b) The Cabinet for Health and Family Services;

(c) The Department for Medicaid Services within the Cabinet for Health and Family Services; and

(d) The Department of Insurance within the Public Protection Cabinet; and

(5) "Telehealth" or "digital health":

(a) Means a mode of delivering healthcare services through the use of telecommunication technologies, including but not limited to synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient or to another health care provider at a different location;

(b) Shall not include:

1. The delivery of health care services through electronic mail, text, chat, or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or

2. Basic communication between a health care provider and a patient, including but not limited to appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to facilitate the actual provision of healthcare services either in-person or via telehealth; and

(c) Unless waived by the applicable federal authority, shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

(1) The cabinet, in consultation with the Division of Telehealth Services within the Office of Health Data and Analytics as established in Section 5 of this Act, shall:

(a) Provide guidance and direction to providers delivering health care services using telehealth or digital health;

(b) Promote access to health care services provided via telehealth or digital health;

(c) Maintain an online telehealth provider directory for consumer use; and

(d) No later than thirty (30) days after the effective date of this Act, promulgate administrative regulations in accordance with KRS Chapter 13A to:

1. Establish a glossary of telehealth terminology to provide standard definitions for all healthcare providers who deliver health care services via telehealth, all state agencies authorized or required to promulgate administrative regulations relating to telehealth, and all payors;

2. Establish minimum requirements for the proper use and security of telehealth, including requirements for confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology;

3. Establish minimum requirements to prevent waste, fraud, and abuse related to telehealth; and

4. Maintain the discretion of state agencies authorized or required to promulgate administrative regulations relating to telehealth to establish requirements to authorize, prohibit, or otherwise govern the use of telehealth in accordance with the state agencies' respective jurisdictions.

(2) In order to comply with the deadline for the promulgation of administrative regulations established in subsection (1)(d) of this section, the cabinet may promulgate emergency administrative regulations in accordance with KRS 13A.190.

(3) The cabinet, in consultation with the Department for Medicaid Services and any managed care organization with whom the department contracts for the delivery of Medicaid services, shall study the impact of telehealth on the health care delivery system in Kentucky and shall submit an annual report to the Legislative Research Commission no later than December 1 of each year. This report shall include analysis of:

(a) The economic impact of telehealth on the Medicaid budget, including any costs or savings as a result of decreased transportation expenditures and office or emergency room visits;

(b) The quality of care as a result of telehealth services;

(c) Reimbursement and delivery of telehealth among all managed care organizations with whom the department contracts for the delivery of Medicaid services; and

(d) Any other issues deemed relevant by the cabinet, including any issues or information deemed relevant by the Division of Telehealth Services pursuant to subsection (4) of Section 5 of this Act.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

If a state agency authorized or required to promulgate administrative regulations relating to telehealth chooses to promulgate an administrative regulation relating to telehealth, the state agency:

(1) Shall:

(a) Use terminology consistent with the glossary of telehealth terminology established by the cabinet pursuant to Section 2 of this Act; and

(b) Comply with the minimum requirements established by the cabinet pursuant to Section 2 of this Act;

(2) Shall not:

(a) Require a provider to be physically present with the recipient, unless the state agency or provider determines that it is medically necessary to perform those services in person;

(b) Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;

(c) Require a provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person;

(d) Require demonstration that it is necessary to provide services to a patient through telehealth;

(e) Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services;

(f) Prohibit the delivery of telehealth services to a person located in Kentucky by a provider who is a participant in a recognized interstate compact and delivers telehealth services to a person in Kentucky under the standards and provisions of that interstate compact;

(g) Prohibit an insurer or managed care organization from utilizing audits for medical coding accuracy in the review of telehealth services specific to audio-only encounters; or

(h) Require a provider to be part of a telehealth network; and

(3) May promulgate administrative regulations, which shall be no more restrictive than administrative regulations for providers who deliver healthcare services in person, to establish additional requirements relating to telehealth, including requirements:

(a) For the proper use and security of telehealth;

(b) To address emergency situations, including but not limited to suicidal ideations or plans; threats to self or others; evidence of dependency, neglect, or abuse; or other life-threatening conditions;

(c) To prevent waste, fraud, and abuse of telehealth services, both in general and specific to the provision of telehealth services delivered via audio-only encounters; or

(d) That a telehealth provider be licensed in Kentucky, or as allowed under the standards and provisions of a recognized interstate compact, in order to receive reimbursement for telehealth services.

➔SECTION 4. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

Nothing in Sections 1 to 4 of this Act shall be interpreted or construed to limit the authority of the Department of Workers' Claims to promulgate administrative regulations governing the delivery of health care services via telehealth or digital health pursuant to KRS Chapter 342.

➔Section 5. KRS 194A.105 is amended to read as follows:

There is hereby created a Division of Telehealth Services within the Office of Health Data and Analytics to be headed by a director appointed by the secretary pursuant to KRS 12.050. The division shall***:***

(1) Provide~~[oversight,]~~ guidance~~[,]~~ and direction to ***healthcare***~~[Medicaid]~~providers delivering care using telehealth***;***~~[. The division shall implement telehealth services and]~~

(2) Develop ~~[standards,]~~guidance, resources, and education to help promote access to healthcare services in the Commonwealth***;***

(3) Assist the Cabinet for Health and Family Services with the implementation of Section 2 of this Act; and

(4) Provide the Department for Medicaid Services with any additional information deemed relevant by the division for inclusion in the report required by subsection (3) of Section 2 of this Act.

➔Section 6. KRS 205.510 is amended to read as follows:

As used in this chapter as it pertains to medical assistance unless the context clearly requires a different meaning:

(1) ***"Behavioral health professional" means a person authorized to provide mental health or substance use disorder services under the laws of the Commonwealth;***

(2) "Chiropractor" means a person authorized to practice chiropractic under ***the laws of the Commonwealth***~~[KRS Chapter 312]~~;

(3)~~[(2)]~~ "Council" means the Advisory Council for Medical Assistance;

(4)~~[(3)]~~ "Dentist" means a person authorized to practice dentistry under laws of the Commonwealth;

(5)~~[(4)]~~ "Health professional" means a physician, physician assistant, nurse, doctor of chiropractic, ***behavioral***~~[mental]~~ health professional, optometrist, dentist, or allied health professional who is licensed in Kentucky;

(6)~~[(5)]~~ "Medical care" as used in this chapter means essential medical, surgical, chiropractic, dental, optometric, podiatric, telehealth, and nursing services, in the home, office, clinic, or other suitable places, which are provided or prescribed by physicians, optometrists, podiatrists, or dentists licensed to render such services, including drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic services, nursing-home and convalescent care, hospital care as defined in KRS 205.560(1)(a), and such other essential medical services and supplies as may be prescribed by such persons; but not including abortions, or induced miscarriages or premature births, unless in the opinion of a physician such procedures are necessary for the preservation of the life of the woman seeking such treatment or except in induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child. However, this section does not authorize optometrists to perform any services other than those authorized by KRS Chapter 320;

(7)~~[(6)]~~ "Nurse" means a person authorized to practice professional nursing under the laws of the Commonwealth;

(8)~~[(7)]~~ "Nursing home" means a facility which provides routine medical care in which physicians regularly visit patients, which provide nursing services and procedures employed in caring for the sick which require training, judgment, technical knowledge, and skills beyond that which the untrained person possesses, and which maintains complete records on patient care, and which is licensed pursuant to the provisions of KRS 216B.015;

(9)~~[(8)]~~ "Optometrist" means a person authorized to practice optometry under the laws of the Commonwealth;

(10)~~[(9)]~~ "Other persons eligible for medical assistance" may include the categorically needy excluded from ***monetary***~~[money]~~ payment status by state requirements and classifications of medically needy individuals as permitted by federal laws and regulations and as prescribed by administrative regulation of the secretary for health and family services or his designee;

(11)~~[(10)]~~ "Pharmacist" means a person authorized to practice pharmacy under the laws of the Commonwealth;

(12)~~[(11)]~~ "Physician" means a person authorized to practice medicine or osteopathy under the laws of the Commonwealth;

(13)~~[(12)]~~ "Podiatrist" means a person authorized to practice podiatry under the laws of the Commonwealth;

(14)~~[(13)]~~ "Primary-care center" means a facility which provides comprehensive medical care with emphasis on the prevention of disease and the maintenance of the patients' health as opposed to the treatment of disease;

(15) ~~[(14)]~~ "Public assistance recipient" means a person who has been certified by the Department for Community Based Services of the Cabinet for Health and Family Services as being eligible for, and a recipient of, public assistance under the provisions of this chapter;

(16) ~~[(15)]~~ "Telehealth" ***means the same as in Section 1 of this Act*** ~~[:~~

~~(a) Means the delivery of health care related services by a Medicaid provider who is a health care provider licensed in Kentucky to a Medicaid recipient through a face-to-face encounter with access to real-time interactive audio and video technology or store and forward services that are provided via asynchronous technologies as the standard practice of care where images are sent to a specialist for evaluation. The requirement for a face-to-face encounter shall be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the Medicaid recipient's medical history prior to the telehealth encounter;~~

~~(b) Shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call; and~~

~~(c) Shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9]~~;

(17) ~~[(16)]~~ "Telehealth consultation" means a medical or health consultation, for purposes of patient diagnosis or treatment, that meets the definition of telehealth in this section;

(18) ~~[(17)]~~ "Third party" means an individual, institution, corporation, company, insurance company, personal representative, administrator, executor, trustee, or public or private agency, including, but not limited to, a reparation obligor and the assigned claims bureau under the Motor Vehicle Reparations Act, Subtitle 39 of KRS Chapter 304, who is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient of medical assistance provided under Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 et seq.; and

(19) ~~[(18)]~~ "Vendor payment" means a payment for medical care which is paid by the Cabinet for Health and Family Services directly to the authorized person or institution which rendered medical care to an eligible recipient.

➔Section 7. KRS 205.559 is amended to read as follows:

(1) The Cabinet for Health and Family Services and any ~~[regional]~~managed care ***organization with whom the Department for Medicaid Services contracts for the delivery of Medicaid services*** ~~[partnership or other entity under contract with the cabinet for the administration or provision of the Medicaid program]~~shall provide Medicaid reimbursement for ***covered*** ~~[a]~~telehealth ***services and telehealth consultations,*** ~~[consultation as defined in KRS 205.510 that is]~~ ***if the telehealth service or telehealth consultation:***

(a) Is provided by a Medicaid-participating practitioner~~[who is licensed in Kentucky]~~***, including those employed by a home health agency licensed pursuant to KRS Chapter 216, to a Medicaid recipient or another Medicaid-participating practitioner at a different physical location; and***

(b) Meets all clinical, technology, and medical coding guidelines for recipient safety and appropriate delivery of services established by the Department for Medicaid Services or the provider's professional licensure board.

(2) (a) ***For rural health clinics, federally qualified health centers, and federally qualified health center look-alikes, reimbursement for covered telehealth services and telehealth consultations shall:*** ~~[The cabinet shall establish reimbursement rates for telehealth consultations]~~

1. To the extent permitted under federal law, include an originating site fee in an amount equal to that which is permitted under 42 U.S.C. sec. 1395m for Medicare-participating providers if the Medicaid beneficiary who received the telehealth service or telehealth consultation was physically located at the rural health clinic, federally qualified health center, or federally qualified health center look-alike at the time of service or consultation delivery and the provider of the telehealth service or telehealth consultation is not employed by the rural health clinic, federally qualified health center, or federally qualified health center look-alike; or

2. If the telehealth service or telehealth consultation provider is employed by the rural health clinic, federally qualified health center, or federally qualified health center look-alike, include a supplemental reimbursement paid by the Department for Medicaid Services in an amount

equal to the difference between the actual reimbursement amount paid by a Medicaid managed care organization and the amount that would have been paid if reimbursement had been made directly by the department.

(b) A request for reimbursement shall not be denied solely because***:***

1. An in-person consultation between a Medicaid-participating practitioner and a patient did not occur***; or***

2. A Medicaid-participating provider employed by a rural health clinic, federally qualified health center, or federally qualified health center look-alike was not physically located on the premises of the clinic or health center when the telehealth service or telehealth consultation was provided.

(c)~~[(b)]~~ ***Telehealth services and telehealth consultations***~~[A telehealth consultation]~~ shall not be reimbursable under this section if ***they are***~~[it is]~~ provided through the use of~~[an audio-only telephone,]~~ ***a*** facsimile machine, ***text, chat,*** or electronic mail ***unless the Department for Medicaid Services determines that telehealth can be provided via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services***.

(3) ***(a)*** A health-care facility that receives reimbursement under this section for consultations provided by a Medicaid-participating provider who practices in that facility and a health professional who obtains a consultation under this section shall establish quality-of-care protocols***, which may include a requirement for an annual in-person or face-to-face consultation with a patient who receives telehealth services,*** and patient confidentiality guidelines to ensure that telehealth consultations meet all requirements and patient care standards as required by law.

(b) The Department for Medicaid Services and any managed care organization with whom the department contracts for the delivery of Medicaid services shall not deny reimbursement for telehealth services covered by this section based solely on quality-of-care protocols adopted by a health-care facility pursuant to paragraph (a) of this subsection.

(4) The cabinet shall not require a telehealth consultation if an in-person consultation with a Medicaid-participating provider is reasonably available where the patient resides, works, or attends school or if the patient prefers an in-person consultation.

(5) The cabinet shall request any waivers of federal laws or regulations that may be necessary to implement this section ***and Section 8 of this Act***.

(6) ~~[(a)]~~***Medicaid-participating practitioners and home health agencies are strongly encouraged to use audio-only encounters as a mode of delivering telehealth services only when no other approved mode of delivering telehealth services is available***~~[The cabinet and any regional managed care partnership or other entity under contract with the cabinet for the administration or provision of the Medicaid program shall study the impact of this section on the health care delivery system in Kentucky and shall, upon implementation, issue an annual report to the Legislative Research Commission. This report shall include an analysis of:~~

~~1. The economic impact of this section on the Medicaid budget, including any costs or savings as a result of decreased transportation expenditures and office or emergency room visits;~~

~~2. The quality of care as a result of telehealth consultations rendered under this section; and~~

~~3. Any other issues deemed relevant by the cabinet.~~

~~(b) In addition to the analysis required under paragraph (a) of this subsection, the cabinet report shall compare telehealth reimbursement and delivery among all regional managed care partnerships or other entities under contract with the cabinet for the administration or provision of the Medicaid program.~~

~~(7) The cabinet shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms, records required, and authorization procedures to be followed in conjunction with this section]~~.

(7) As used in this section:

(a) "Federally qualified health center" means the same as in 42 U.S.C. sec. 1396d;

(b) "Federally qualified health center look-alike" means an organization that meets all of the eligibility requirements of a federally qualified health center but does not receive federal grants issued pursuant to 42 U.S.C. sec. 254b;

(c) "Originating site" means the site at which a Medicaid beneficiary is physically located at the time a telehealth service or telehealth consultation is provided; and

(d) "Rural health clinic" means the same as in 42 U.S.C. sec. 1395x.

➔Section 8. KRS 205.5591 is amended to read as follows:

(1) The cabinet shall provide oversight, guidance, and direction to Medicaid providers delivering care using telehealth~~[as defined in KRS 205.510]~~.

(2) The ***Department for Medicaid Services***~~[cabinet]~~shall:

(a) ***Within thirty (30) days after the effective date of this Act:***

1. Promulgate administrative regulations in accordance with KRS Chapter 13A to establish requirements for telehealth coverage and reimbursement rates, which shall be equivalent to coverage requirements and reimbursement rates for the same service provided in person unless the telehealth provider and the department or a managed care organization contractually agree to a lower reimbursement rate for telehealth services; and

2. Create, establish, or designate the claim forms, records required, and authorization procedures to be followed in conjunction with this section and Section 7 of this Act~~[Develop policies and procedures to ensure the proper use and security for telehealth, including but not limited to confidentiality and data integrity, privacy and security, informed consent, privileging and credentialing, reimbursement, and technology;~~

~~(b) Promote access to health care provided via telehealth;~~

~~(c) Maintain a list of Medicaid providers who may deliver telehealth services to Medicaid recipients throughout the Commonwealth]~~;

(b)~~[(d)]~~ Require that specialty care be rendered by a health care provider who is recognized and actively participating in the Medicaid program;~~[and]~~

(c)~~[(e)]~~ Require that any required prior authorization requesting a referral or consultation for specialty care be processed by the patient's primary care provider and that any specialist coordinate care with the patient's primary care provider***; and***

(d) Require a telehealth provider to be licensed in Kentucky, or as allowed under the standards and provisions of a recognized interstate compact, in order to receive reimbursement for telehealth services.

(3) ***In accordance with Section 3 of this Act, the Department for Medicaid Services and any***~~[The cabinet or a Medicaid]~~ managed care organization ***with whom the department contracts for the delivery of Medicaid services*** shall not:

(a) Require a Medicaid provider to be physically present with a Medicaid recipient, unless the provider determines that it is medically necessary to perform those services in person;

(b) Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;

(c) Require a Medicaid provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person;

(d) Require demonstration that it is necessary to provide services to a Medicaid recipient through telehealth;

(e) Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services; or

(f) Require a Medicaid provider to be part of a telehealth network.

(4) ~~[The Medicaid program or a Medicaid managed care organization shall require a telehealth provider to be licensed in Kentucky in order to receive reimbursement for telehealth services.~~

~~(5) The Medicaid program or a Medicaid managed care organization shall reimburse for covered services provided to a Medicaid recipient through telehealth, as defined in KRS 205.510. The department shall promulgate administrative regulations to establish requirements for telehealth coverage and reimbursement, which shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the Medicaid program or a Medicaid managed care organization contractually agree to a lower reimbursement rate for telehealth services, or the department establishes a different reimbursement rate.~~

~~(6) ~~]Benefits for a service provided to a Medicaid recipient through telehealth may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the Medicaid program for the same service provided in person.

(5) ~~[(7)]~~ Nothing in this section shall be construed to require the Medicaid program or a Medicaid managed care organization to:

(a) Provide coverage for telehealth services that are not medically necessary; or

(b) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

(6) ~~[(8)]~~ The cabinet***, in implementing Sections 2 and 3 of this Act,*** shall maintain telehealth policies and guidelines to providing care that ensure that Medicaid-eligible citizens will have safe, adequate, and efficient medical care, and that prevent waste, fraud, and abuse of the Medicaid program.

(7) In order to comply with the deadline for the promulgation of administrative regulations established in subsection (2) of this section, the Department for Medicaid Services may promulgate emergency administrative regulations in accordance with KRS 13A.190.

➔Section 9. KRS 304.17A-005 is amended to read as follows:

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

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

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

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

(7) "COBRA" means any of the following:

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

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

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

(8) "Creditable coverage":

(a) Means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

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

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

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

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

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;

9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)); or

11. Title XXI of the Social Security Act, such as the State Children's Health Insurance Program; and

(b) Does not include coverage consisting solely of coverage of excepted benefits as defined in this section;

(9) "Dependent" means any individual who is or may become eligible for coverage under the terms of an individual or group health benefit plan because of a relationship to a participant;

(10) "Employee benefit plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan as defined by ERISA;

(11) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

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

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled;

(c) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare benefit plan under guidance issued by the United States Department of Labor prior to the issuance of 29 C.F.R. sec. 2510.3-5, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation; and

(d) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare benefit plan, whose members consist of employers or a group of employers that satisfy the requirements of 29 C.F.R. sec. 2510.3-5.

Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, except that an employer-organized association as defined under paragraph (c) or (d) of this subsection shall be treated as a large group under this subtitle;

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

(14) "Excepted benefits" means benefits under one (1) or more, or any combination of the following:

(a) Coverage only for accident, including accidental death and dismemberment, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families;

(17) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(18) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

(19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

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

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

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

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

(22) "Health benefit plan":

(a) Shall include any:

1. Hospital or medical expense policy or certificate;

2. Nonprofit hospital, medical-surgical, and health service corporation contract or certificate;

3. Provider sponsored integrated health delivery network;

4. Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;

5. Self-insured governmental plan or church plan;

6. Health maintenance organization contract, except contracts to provide Medicaid benefits under KRS Chapter 205; or

7. Health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky; and

(b) Does not include:

1. Policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement, long-term care, Medicare supplement, specified disease, or vision care;

2. Coverage issued as a supplement to liability insurance;

3. Insurance arising out of a workers' compensation or similar law;

4. Automobile medical-payment insurance;

5. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

6. Short-term limited-duration coverage;

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

8. Medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract;

9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

10. Limited health service benefit plans;

11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199; or

12. Coverage provided under KRS Chapter 205;

(23) "Health care provider" or "provider" means any:

(a) Advanced practice registered nurse licensed under KRS Chapter 314;

(b) Chiropractor licensed under KRS Chapter 312;

(c) Dentist licensed under KRS Chapter 313;

(d) Facility or service required to be licensed under KRS Chapter 216B;

(e) Home medical equipment and services provider licensed under KRS Chapter 309;

(f) Optometrist licensed under KRS Chapter 320;

(g) Pharmacist licensed under KRS Chapter 315;

(h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;

(i) Physician assistant regulated under KRS Chapter 311; and

(j) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "Health care service" means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

(b) Health care service includes the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

(25) "Health facility" or "facility" has the same meaning as in KRS 216B.015;

(26) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds

the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

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

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

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

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

(27) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(28) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer-related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association;

(29) "Insurer" means any insurance company; health maintenance organization; self-insurer, including a governmental plan, church plan, or multiple employer welfare arrangement, not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

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

(31) "Kentucky Access" has the meaning provided in KRS 304.17B-001;

(32) "Large group" means:

(a) An employer with fifty-one (51) or more employees;

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) A fully insured employer-organized association as defined in subsection (12)(c) or (d) of this section that:

1. Covers at least fifty-one (51) employee members; and

2. Is registered with the department pursuant to administrative regulations promulgated by the commissioner;

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

(34) "Market segment" means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(35) "Medically necessary health care services" means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(a) In accordance with generally accepted standards of medical practice; and

(b) Clinically appropriate in terms of type, frequency, extent, and duration;

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

(37) "Preventive services" means medical services for the early detection of disease that are associated with substantial reduction in morbidity and mortality;

(38) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(39) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(40) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(41) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(42) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(43) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

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

(45) "Small group" means:

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

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

and

(46) "Standard benefit plan" means the plan identified in KRS 304.17A-250~~[; and~~

~~(47) "Telehealth":~~

~~(a) Means the delivery of health care-related services by a health care provider who is licensed in Kentucky to a patient or client through a face-to-face encounter with access to real-time interactive audio and video technology or store-and-forward services that are provided via asynchronous technologies as the standard practice of care where images are sent to a specialist for evaluation. The requirement for a face-to-face encounter shall be satisfied with the use of asynchronous telecommunications technologies in which the health care provider has access to the patient's or client's medical history prior to the telehealth encounter;~~

~~(b) Shall not include the delivery of services through electronic mail, text chat, facsimile, or standard audio-only telephone call; and~~

~~(c) Shall be delivered over a secure communications connection that complies with the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d to 1320d-9~~].

➔Section 10. KRS 304.17A-138 is amended to read as follows:

(1) ***As used in this section:***

(a) "Federally qualified health center" means the same as in 42 U.S.C. sec. 1396d;

(b) "Federally qualified health center look-alike" means an organization that meets all of the eligibility requirements of a federally qualified health center but does not receive federal grants issued pursuant to 42 U.S.C. sec. 254b;

(c) "Originating site" means the site at which a Medicaid beneficiary is physically located at the time a telehealth service or telehealth consultation is provided;

(d) "Provider" means the same as in Section 9 of this Act and also includes behavioral health professionals licensed under KRS Chapters 309, 319, and 335; and

(e) "Telehealth" has the same meaning as in Section 1 of this Act; and

(f) "Rural health clinic" means the same as in 42 U.S.C. sec. 1395x.

(2) (a) A health benefit plan***, issued or renewed on or after the effective date of this section,*** shall reimburse for covered services provided to an insured person through telehealth***, including telehealth services provided by a home health agency licensed under KRS Chapter 216***[~~, as defined in KRS 304.17A-005~~]. Telehealth coverage and reimbursement shall***, except as provided in paragraph (b) of this subsection,*** be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services.

(b) Rural health clinics, federally qualified health centers, and federally qualified health center look-alikes shall be reimbursed as an originating site in an amount equal to that which is permitted under 42 U.S.C. sec. 1395m for Medicare-participating providers, if the insured was physically located at the rural health clinic, federally qualified health center, or federally qualified health center look-alike at the time of service or consultation delivery and the provider of the telehealth service or telehealth consultation is not employed by the rural health clinic, federally qualified health center, or federally qualified health center look-alike.

(3)[~~(b)~~] ***In accordance with Section 3 of this Act,*** a health benefit plan***, issued or renewed on or after the effective date of this section:***

(a) Shall not:

1. Require a provider to be physically present with a patient or client, unless the provider determines that it is necessary to perform those services in person;

2. Require prior authorization, medical review, or administrative clearance for telehealth that would not be required if a service were provided in person;

3. Require demonstration that it is necessary to provide services to a patient or client through telehealth;

4. Require a provider to be employed by another provider or agency in order to provide telehealth services that would not be required if that service were provided in person;

5. Restrict or deny coverage of telehealth based solely on the communication technology or application used to deliver the telehealth services; or

6. Require a provider to be part of a telehealth network***;***

(b) Shall:

1. Require that telehealth services reimbursed under this section meet all clinical, technology, and medical coding guidelines for recipient safety and appropriate delivery of services established by the Department of Insurance or the provider's professional licensure board;

2. Require a telehealth provider to be licensed in Kentucky, or as allowed under the standards and provisions of a recognized interstate compact, in order to receive reimbursement for telehealth services; and

3. Reimburse a rural health clinic, federally qualified health clinic, or federally qualified health center look-alike for covered telehealth services provided by a provider employed by the rural health clinic, federally qualified health clinic, or federally qualified health center look-alike, regardless of whether the provider was physically located on the premises of the rural health clinic, federally qualified health clinic, or federally qualified health clinic look-alike when the telehealth service was provided; and

(c) May utilize audits for medical coding accuracy in the review of telehealth services specific to audio-only encounters.

(4)~~[(2) A health benefit plan shall require a telehealth provider to be licensed in Kentucky in order to receive reimbursement for telehealth services.~~

~~(3)]~~ Benefits for a service provided through telehealth required by this section may be made subject to a deductible, copayment, or coinsurance requirement. A deductible, copayment, or coinsurance applicable to a particular service provided through telehealth shall not exceed the deductible, copayment, or coinsurance required by the health benefit plan for the same service provided in person.

(5)~~[(4)]~~ Nothing in this section shall be construed to require a health benefit plan to:

(a) Provide coverage for telehealth services that are not medically necessary; or

(b) Reimburse any fees charged by a telehealth facility for transmission of a telehealth encounter.

~~[(5) Payment made under this section may be consistent with any provider network arrangements that have been established for the health benefit plan.]~~

(6) ***Providers and home health agencies are strongly encouraged to use audio-only encounters as a mode of delivering telehealth services when no other approved mode of delivering telehealth services is available.***

(7) The department shall promulgate an administrative regulation in accordance with KRS Chapter 13A to designate the claim forms and records required to be maintained in conjunction with this section.

➔Section 11. KRS 342.315 is amended to read as follows:

(1) For workers who have had injuries or occupational hearing loss, the commissioner shall contract with the University of Kentucky and the University of Louisville medical schools to evaluate workers. For workers who have become affected by occupational diseases, the commissioner shall contract with the University of Kentucky and the University of Louisville medical schools, or other physicians otherwise duly qualified as "B" readers who are licensed in the Commonwealth and are board-certified pulmonary specialists. Referral for evaluation may be made whenever a medical question is at issue.

(2) The physicians and institutions performing evaluations pursuant to this section shall render reports encompassing their findings and opinions in the form prescribed by the commissioner. Except as otherwise provided in KRS 342.316, the clinical findings and opinions of the designated evaluator shall be afforded presumptive weight by administrative law judges and the burden to overcome such findings and opinions shall fall on the opponent of that evidence. When administrative law judges reject the clinical findings and opinions of the designated evaluator, they shall specifically state in the order the reasons for rejecting that evidence.

(3) The commissioner or an administrative law judge may, upon the application of any party or upon his own motion, direct appointment by the commissioner, pursuant to subsection (1) of this section, of a medical evaluator to make any necessary medical examination of the employee. Such medical evaluator shall file with the commissioner within fifteen (15) days after such examination a written report. The medical evaluator appointed may charge a reasonable fee not exceeding fees established by the commissioner for those services.

(4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer or carrier shall pay the cost of the examination. Upon notice from the commissioner that an evaluation has been scheduled, the insurance carrier shall forward within seven (7) days to the employee the expenses of travel necessary to attend the evaluation at a rate equal to that paid to state employees for travel by private automobile while conducting state business.

(5) Upon claims in which it is finally determined that the injured worker was not the employee at the time of injury of an employer covered by this chapter, the special fund shall reimburse the carrier for any evaluation performed pursuant to this section for which the carrier has been erroneously compelled to make payment.

(6) Not less often than annually the designee of the secretary of the Cabinet for Health and Family Services shall assess the performance of the medical schools and render findings as to whether evaluations conducted under this section are being rendered in a timely manner, whether examinations are conducted in accordance with medically recognized techniques, whether impairment ratings are in conformity with standards prescribed by the "Guides to the Evaluation of Permanent Impairment," and whether coal workers' pneumoconiosis examinations are conducted in accordance with the standards prescribed in this chapter.

(7) The General Assembly finds that good public policy mandates the realization of the potential advantages, both economic and effectual, of the use of telehealth. The commissioner may, to the extent that he or she finds it feasible and appropriate, require the use of telehealth, as defined in ***Section 1 of this Act***~~[KRS 304.17A-005]~~, in the independent medical evaluation process required by this chapter.

➔Section 12. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a waiver or any other authorization from a federal agency is necessary prior to the implementation of any provision of Section 7 or 8 of this Act, the cabinet or department shall, within 90 days after the effective date of this Act, request the waiver or authorization and shall only delay full implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 13. Sections 9 and 10 of this Act take effect January 1, 2022.

Signed by Governor March 22, 2021.