CHAPTER 19

(SB 140)

AN ACT relating to step therapy protocols.

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

➔Section 1. KRS 304.17A-163 is amended to read as follows:

(1) As used in this section ***and Section 2 of this Act***, unless the context requires otherwise:

(a) ***"Clinical practice guidelines" means a systematically developed statement to assist decision making by health care providers and patients about appropriate healthcare for specific clinical circumstances and conditions;***

(b) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by the insurer, health plan, pharmacy benefit manager, or private review agent to determine the medical necessity and appropriateness of health care services;

(c) "Health plan":

1. Means any state-regulated policy, certificate, contract, or plan that offers or provides coverage in this state, by direct payment, reimbursement, or otherwise, for prescription drugs pursuant to a step therapy protocol, regardless of whether the protocol is described as a step therapy protocol; and

2. Shall include but not be limited to a health benefit plan;

(d) "Pharmacy benefit manager" has the same meaning as in KRS 304.9-020;

(e) "Private review agent" has the same meaning as in KRS 304.17A-600;

(f) "Step therapy ***exception***" means a ***determination that a step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug; and***

(g) "Step therapy protocol" means a protocol, policy, or program that establishes the specific sequence in which prescription drugs that are for a specified medical condition and medically appropriate for a particular insured are covered by an insurer or health plan~~[protocol that establishes the specific sequence in which prescription drugs for a specified medical condition and medically appropriate for a particular patient are to be prescribed;~~

~~(b) "Fail-first protocol" has the same meaning as step therapy in paragraph (a) of this subsection;~~

~~(c) "Override of the restriction" means the permission to deviate from the required sequence by prescribing another drug that is medically necessary; and~~

~~(d) "Insurer" has the same meaning as in KRS 304.17A-005]~~.

(2) ***(a) Except as provided in paragraph (b) of this subsection, clinical review criteria developed by an insurer, health plan, pharmacy benefit manager, or private review agent to establish a step therapy protocol shall be based on clinical practice guidelines that:***

1. Recommend that prescription drugs be taken in the specific sequence required by the step therapy protocol;

2. Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

a. Requiring members to:

i. Disclose any potential conflict of interests with entities, including insurers, health plans, and pharmaceutical manufacturers; and

ii. Recuse himself or herself from voting if the member has a conflict of interest;

b. Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

c. Offering opportunities for public review and comments;

3. Are based on high quality studies, research, and medical practice;

4. Are created by an explicit and transparent process that:

a. Minimizes biases and conflicts of interest;

b. Explains the relationship between treatment options and outcomes;

c. Rates the quality of the evidence supporting recommendations; and

d. Considers relevant patient subgroups and preferences; and

5. Are continually updated through a review of new evidence, research, and newly developed treatments.

(b) In the absence of clinical practice guidelines that meet the requirements of paragraph (a) of this subsection, an insurer, health plan, pharmacy benefit manager, or private review agent may use peer-reviewed publications to establish step therapy protocols.

(c) When establishing clinical review criteria for a step therapy protocol, an insurer, health plan, pharmacy benefit manager, or private review agent shall take into account the needs of atypical patient populations and diagnoses.

(d) 1. An insurer, health plan, pharmacy benefit manager, or private review agent shall, upon written request, provide all specific written clinical review criteria relating to a particular condition or disease, including clinical review criteria relating to a step therapy exception determination.

2. The clinical review criteria and other clinical information shall be made available:

a. On the insurer's, health plan's, pharmacy benefit manager's, or private review agent's Web site; and

b. To a health care professional on behalf of an insured upon written request.

(e) Nothing in this subsection shall be construed to require an insurer, health plan, pharmacy benefit manager, or private review agent to establish a new entity to develop clinical review criteria used for step therapy protocols.

(3) (a) When ***coverage of a prescription drug***~~[medications]~~ for the treatment of any medical condition ***is***~~[are]~~ restricted for use by an insurer***, health plan, private review agent,*** or a pharmacy benefit manager by a step therapy~~[or fail-first]~~protocol, the ***insured and*** prescribing ***provider***~~[practitioner]~~ shall have access to a clear***, readily accessible,*** and convenient process to request ***a step therapy exception***~~[an override of the restriction from the insurer]~~.

(b) An insurer, health plan, private review agent, or pharmacy benefit manager:

1. May use its existing medical exceptions process to satisfy the requirements of paragraph (a) of this subsection;

2. Shall make the step therapy protocol easily accessible on its Web site; and

3. Shall, upon request, disclose all rules and criteria related to the step therapy protocol to all prescribing providers, including the specific information and documentation that must be submitted by a prescribing provider or insured to be considered a complete request for a step therapy exception.

(4) (a) A step therapy exception request, or an internal appeal under Section 7 of this Act of a step therapy exception request denial,~~[An override of the restriction]~~ shall be granted by the insurer***, health plan, private review agent,*** or the pharmacy benefit manager within forty-eight (48) hours~~[,]~~ if***:***

1. All necessary information to perform the ***step therapy exception***~~[override]~~ review***, or make the appeal determination,*** has been provided***; and***~~[, under the following documented circumstances:]~~

2. One (1) of the following apply:

a. The required prescription drug is:

i. Contraindicated or will likely cause an adverse reaction by physical or mental harm to the insured; or

ii. Expected to be ineffective based on the known clinical characteristics of the insured and the prescription drug regimen;

b. Based on clinical appropriateness, the required prescription drug is not in the best interest of the insured because the insured's use of the required prescription drug is expected to:

i. Cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;

ii. Worsen a comorbid condition of the insured; or

iii. Decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities;

c. The insured has tried the required prescription drug while under the insured's current or a previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or

d. The insured is stable on the prescription drug selected by the insured's health care provider for the medical condition under consideration while under a current or previous health plan.

(b) If a request for a step therapy exception, or an internal appeal under Section 7 of this Act of a step therapy exception request denial, is incomplete or additional clinically relevant information is required, the insurer, health plan, pharmacy benefit manager, or private review agent shall notify the prescribing provider within forty-eight (48) hours of submission of the request or appeal:

1. That the request or appeal is incomplete; and

2. What additional or clinically relevant information is required in order to approve or deny the step therapy exception.

~~[(a) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the insured's disease or medical condition; or~~

~~(b) Based on sound clinical evidence or medical and scientific evidence:~~

~~1. The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or~~

~~2. The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.]~~

(5) If a step therapy exception request determination, notification under subsection (4)(b) of this section, or internal appeal determination under Section 7 of this Act of a step therapy exception request denial by an insurer, health plan, pharmacy benefit manager, or private review agent is not received by the prescribing provider within the time period specified in subsection (4) of this section, the step therapy exception request or internal appeal shall be deemed granted.

(6) An insured or a provider may:

(a) Initiate an internal appeal under Section 7 of this Act upon the denial of a step therapy exception request under this section; and

(b) Request an external review under Section 8 of this Act upon the denial of an internal appeal under paragraph (a) of this subsection.

(7) An insurer, health plan, pharmacy benefit manager, or private review agent shall:

(a) Upon the granting of a step therapy exception request, internal appeal, or external review, authorize coverage for the prescription drug selected by the insured's health care provider; or

(b) Upon the denial of a step therapy exception request or internal appeal, inform the insured of the internal appeal or external review process, as applicable.

(8) (a) ~~[(3)]~~ ***Except as provided in paragraph (b) of this subsection,*** the duration of any step therapy ~~[or fail-first]~~protocol shall not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing ***provider*** ~~[practitioner]~~.

(b) When the prescribing ***provider*** ~~[practitioner]~~ can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy ~~[or fail-first]~~protocol may be extended up to seven (7) additional days.

(9) Nothing in this section shall be construed to prevent:

(a) An insurer, health plan, pharmacy benefit manager, or private review agent from requiring:

1. An insured to try an AB-rated generic equivalent or interchangeable biological product, as defined in 42 U.S.C. sec. 262(i)(3), prior to providing coverage for the equivalent branded prescription drug, unless the requirement meets any of the criteria set forth in subsection (4)(a)2. of this section pursuant to a step therapy exception request submitted under subsection (4) of this section; or

2. A pharmacist to effect substitutions of prescription drugs consistent with KRS 217.814 to 217.896 and Section 4 of this Act; or

(b) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

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

(1) Notwithstanding any other law to the contrary, the commissioner shall promulgate any administrative regulations necessary to enforce this section and Section 1 of this Act.

(2) Annually, an insurer, health plan, pharmacy benefit manager, or private review agent shall report to the commissioner, in a format prescribed by the commissioner:

(a) The number of step therapy exception requests received, by exception as set forth in subsection (4)(a)2. of Section 1 of this Act;

(b) The type of health care providers, or the medical specialties of the health care providers, that submitted step therapy exception requests;

(c) The number of step therapy exceptions, by exception as set forth in subsection (4)(a)2. of Section 1 of this Act, that were:

1. Denied, and the reason for the denial;

2. Approved;

3. Initially denied and then appealed; and

4. Initially denied and then subsequently reversed by internal appeals or external reviews; and

(d) The medical conditions for which insureds were granted step therapy exceptions due to the likelihood that switching the prescription drug would likely cause an adverse reaction by physical or mental harm to the insured.

➔Section 3. KRS 304.17A-168 is amended to read as follows:

(1) Notwithstanding any provision of law to the contrary, a health benefit plan shall, at a minimum, provide coverage for all United States Food and Drug Administration-approved tobacco cessation medications, all

forms of tobacco cessation services recommended by the United States Preventive Services Task Force, including but not limited to individual, group, and telephone counseling, and any combination thereof.

(2) The following conditions shall not be imposed on any tobacco cessation services provided pursuant to this section:

(a) Counseling requirements for medication;

(b) Limits on the duration of services, including but not limited to annual or lifetime limits on the number of covered attempts to quit; or

(c) Copayments or other out-of-pocket cost sharing, including deductibles.

(3) Utilization management requirements, including prior authorization and step therapy ***protocol***, shall not be imposed on any tobacco cessation services provided pursuant to this section, except in the following circumstances where prior authorization may be required:

(a) For a treatment that exceeds the duration recommended by the most recently published United States Public Health Service clinical practice guidelines on treating tobacco use and dependence; or

(b) For services associated with more than two (2) attempts to quit within a twelve (12) month period.

(4) Nothing in this section shall be construed to prohibit a plan or issuer from providing coverage for tobacco cessation services in addition to those recommended or to deny coverage for services that are not recommended by the United States Preventive Services Task Force.

➔Section 4. KRS 304.17A-535 is amended to read as follows:

(1) A managed care plan shall include a drug utilization review program, the primary emphasis of which shall be to enhance quality of care for enrollees by assuring appropriate drug therapy within the health care provider's legally authorized scope of practice, that***:***

(a) Includes the following:

1.~~[(a)]~~ Retrospective review of prescription drugs furnished to enrollees;

2.~~[(b)]~~ Education of health care providers and enrollees regarding the appropriate use of prescription drugs; and

3.~~[(c)]~~ Ongoing periodic examination of data on outpatient prescription drugs to ensure quality therapeutic outcomes for enrollees***; and***

(b) Complies with Sections 1 and 2 of this Act.

(2) The drug utilization review program shall utilize the following to effectuate the purposes of subsection (1) of this section:

(a) Relevant clinical criteria and standards for drug therapy;

(b) Nonproprietary criteria and standards developed and revised through input from participating health care providers;

(c) Intervention that focuses on improving therapeutic outcomes; and

(d) Measures to ensure the confidentiality of the relationship between an enrollee and a health care provider.

(3) When, in the professional opinion of a provider with prescriptive authority, the provider determines that generic substitution of a pharmaceutical product is medically inappropriate, the provider shall prescribe the pharmaceutical product the provider determines medically appropriate with the indication "Do Not Substitute," and no substitution shall be made without the provider's approval.

(4) A managed care plan that restricts pharmacy benefits to a drug formulary shall have an exceptions policy through which the managed care plan may cover a prescription drug not included on the formulary.

➔Section 5. KRS 304.17A-600 is amended to read as follows:

As used in KRS 304.17A-600 to 304.17A-633:

(1) (a) "Adverse determination" means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and

2. Benefit coverage is therefore denied, reduced, or terminated.

(b) "Adverse determination" does not mean a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a covered person are specifically limited or excluded in the covered person's health benefit plan;

(2) "Authorized person" means a parent, guardian, or other person authorized to act on behalf of a covered person with respect to health care decisions;

(3) "Concurrent review" means utilization review conducted during a covered person's course of treatment or hospital stay;

(4) "Covered person" means a person covered under a health benefit plan;

(5) "External review" means a review that is conducted by an independent review entity which meets specified criteria as established in KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(6) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except that for purposes of KRS 304.17A-600 to 304.17A-633, the term includes short-term coverage policies;

(7) "Independent review entity" means an individual or organization certified by the department to perform external reviews under KRS 304.17A-623, 304.17A-625, and 304.17A-627;

(8) "Insurer" means any of the following entities authorized to issue health benefit plans as defined in subsection (6) of this section: an insurance company, health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association; nonprofit hospital, medical-surgical, or health service corporation; or any other entity authorized to transact health insurance business in Kentucky;

(9) "Internal appeals process" means a formal process, as set forth in KRS 304.17A-617, established and maintained by the insurer, its designee, or agent whereby the covered person, an authorized person, or a provider may contest an adverse determination rendered by the insurer, its designee, or private review agent;

(10) "Nationally recognized accreditation organization"***:***

(a) Means a private nonprofit entity that***:***

1. Sets national utilization review and internal appeal standards***;*** and

2. Conducts review of insurers, agents, or independent review entities for the purpose of accreditation or certification***; and***~~[. Nationally recognized accreditation organizations]~~

(b) Shall include the Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), the American Accreditation Health Care Commission (URAC), the Joint Commission, or any other organization identified by the department;

(11) "Private review agent" or "agent"***:***

(a) Means a person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of any insurer or other person providing or administering health benefits to citizens of this Commonwealth***; and***~~[. "Private review agent" or "agent"]~~

(b) Does not include an independent review entity which performs external review of adverse determinations;

(12) "Prospective review" means a utilization review that is conducted prior to the provision of health care services. "Prospective review" also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy ***protocol***, preadmission review, pretreatment review, utilization, and case management;

(13) "Qualified personnel" means licensed physician, registered nurse, licensed practical nurse, medical records technician, or other licensed medical personnel who through training and experience shall render consistent decisions based on the review criteria;

(14) "Registration" means an authorization issued by the department to an insurer or a private review agent to conduct utilization review;

(15) "Retrospective review"***:***

(a) Means utilization review that is conducted after health care services have been provided to a covered person***; and***~~[. "Retrospective review"]~~

(b) Does not include the review of a claim that is limited to an evaluation of reimbursement levels, or adjudication of payment;

(16) (a) "Urgent health care services" means health care or treatment with respect to which the application of the time periods for making nonurgent determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

(b) Urgent health care services include all requests for hospitalization and outpatient surgery;

(17) "Utilization review" means a review of the medical necessity and appropriateness of hospital resources and medical services given or proposed to be given to a covered person for purposes of determining the availability of payment. Areas of review include concurrent, prospective, and retrospective review; and

(18) "Utilization review plan" means a description of the procedures governing utilization review activities performed by an insurer or a private review agent.

➔Section 6. KRS 304.17A-607 is amended to read as follows:

(1) An insurer or private review agent shall not provide or perform utilization reviews without being registered with the department. A registered insurer or private review agent shall:

(a) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported by licensed physicians with access to consultation with other appropriate physicians to carry out its utilization review activities;

(b) Ensure that, for any contract entered into on or after January 1, 2020, for the provision of utilization review services, only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, shall:

1. Make a utilization review decision to deny, reduce, limit, or terminate a health care benefit or to deny, or reduce payment for a health care service because that service is not medically necessary, experimental, or investigational except in the case of a health care service rendered by a chiropractor or optometrist where the denial shall be made respectively by a chiropractor or optometrist duly licensed in Kentucky; and

2. Supervise qualified personnel conducting case reviews;

(c) Have available the services of sufficient numbers of practicing physicians in appropriate specialty areas to assure the adequate review of medical and surgical specialty and subspecialty cases;

(d) Not disclose or publish individual medical records or any other confidential medical information in the performance of utilization review activities except as provided in the Health Insurance Portability and Accountability Act, Subtitle F, secs. 261 to 264 and 45 C.F.R. secs. 160 to 164 and other applicable laws and administrative regulations;

(e) Provide a toll free telephone line for covered persons, authorized persons, and providers to contact the insurer or private review agent and be accessible to covered persons, authorized persons, and providers for forty (40) hours a week during normal business hours in this state;

(f) Where an insurer, its agent, or private review agent provides or performs utilization review, be available to conduct utilization review during normal business hours and extended hours in this state on Monday and Friday through 6:00 p.m., including federal holidays;

(g) Provide decisions to covered persons, authorized persons, and all providers on appeals of adverse determinations and coverage denials of the insurer or private review agent, in accordance with this section and administrative regulations promulgated in accordance with KRS 304.17A-609;

(h) Except for retrospective review of an emergency admission where the covered person remains hospitalized at the time the review request is made, which shall be considered a concurrent review, or as otherwise provided in this subtitle, provide a utilization review decision in accordance with the timeframes in paragraph (i) of this subsection and 29 C.F.R. Part 2560, including written notice of the decision;

(i) 1. Render a utilization review decision concerning urgent health care services, and notify the covered person, authorized person, or provider of that decision no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision; and

2. If the insurer or agent requires a utilization review decision of nonurgent health care services, render a utilization review decision and notify the covered person, authorized person, or provider of the decision within five (5) days of obtaining all necessary information to make the utilization review decision.

For purposes of this paragraph, "necessary information" is limited to:

a. The results of any face-to-face clinical evaluation;

b. Any second opinion that may be required; and

c. Any other information determined by the department to be necessary to making a utilization review determination;

(j) Provide written notice of review decisions to the covered person, authorized person, and providers. The written notice may be provided in an electronic format, including e-mail or facsimile, if the covered person, authorized person, or provider has agreed in advance in writing to receive the notices electronically. An insurer or agent that denies ***a*** step therapy ***exception***, as defined in KRS 304.17A-163,~~[overrides]~~ or denies coverage or reduces payment for a treatment, procedure, drug that requires prior approval, or device shall include in the written notice:

1. A statement of the specific medical and scientific reasons for denial or reduction of payment or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The medical license number and the title of the reviewer making the decision;

3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating or complying with the insurer's internal appeal procedure, as set forth in KRS 304.17A-617, stating, at a minimum, whether the appeal shall be in writing, and any specific filing procedures, including any applicable time limitations or schedules, and the position and phone number of a contact person who can provide additional information;

(k) Afford participating physicians an opportunity to review and comment on all medical and surgical and emergency room protocols, respectively, of the insurer and afford other participating providers an opportunity to review and comment on all of the insurer's protocols that are within the provider's legally authorized scope of practice; and

(l) Comply with its own policies and procedures on file with the department or, if accredited or certified by a nationally recognized accrediting entity, comply with the utilization review standards of that accrediting entity where they are comparable and do not conflict with state law.

(2) The insurer's or private review agent's failure to make a determination and provide written notice within the time frames set forth in this section shall be deemed to be a prior authorization for the health care services or benefits subject to the review. This provision shall not apply where the failure to make the determination or provide the notice results from circumstances which are documented to be beyond the insurer's control.

(3) An insurer or private review agent shall submit a copy of any changes to its utilization review policies or procedures to the department. No change to policies and procedures shall be effective or used until after it has been filed with and approved by the commissioner.

(4) A private review agent shall provide to the department the names of the entities for which the private review agent is performing utilization review in this state. Notice shall be provided within thirty (30) days of any change.

➔Section 7. KRS 304.17A-617 is amended to read as follows:

(1) ***(a)*** Every insurer shall have an internal appeal process to be utilized by the insurer or its designee, consistent with this section and KRS 304.17A-619 and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).

(b) An insurer shall disclose the availability of the internal process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial which meets the requirements set forth in KRS 304.17A-607(1)(j).

(c) For purposes of this section, "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(d) Where a coverage denial is involved, in addition to stating the reason for the coverage denial, the required notice shall contain instructions for filing a request for internal appeal.

(2) The internal appeals process may be initiated by the covered person, an authorized person, or a provider acting on behalf of the covered person.

(3) The internal appeals process shall include adequate and reasonable procedures for review and resolution of appeals concerning adverse determinations made under utilization review and of coverage denials, including procedures for reviewing appeals from covered persons whose medical conditions require expedited review. At a minimum, these procedures shall include the following:

(a) ***Except as provided in Section 1 of this Act:***

1. Insurers or their designees shall provide decisions to covered persons, authorized persons, and providers on internal appeals of adverse determinations or coverage denials within thirty (30) days of receipt of the request for internal appeal; ***and***

2.~~[(b)]~~ Insurers or their designees shall render a decision not later than three (3) business days after receipt of the request for an expedited appeal of either an adverse determination or a coverage denial. An expedited appeal is deemed necessary when a covered person is hospitalized or, in the opinion of the treating provider, review under a standard time frame could, in the absence of immediate medical attention, result in any of the following:

a.~~[1.]~~ Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or the unborn child in serious jeopardy;

b.~~[2.]~~ Serious impairment to bodily functions; or

c.~~[3.]~~ Serious dysfunction of a bodily organ or part;

(b)~~[(c)]~~ Internal appeal of an adverse determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, the insurer or agent shall, upon request by a covered person, authorized person, or provider, utilize a board eligible or certified physician in the appropriate specialty or subspecialty area to conduct the internal appeal;

(c)~~[(d)]~~ Those portions of the medical record that are relevant to the internal appeal, if authorized by the covered person and in accordance with state or federal law, shall be considered and providers given the opportunity to present additional information; and

(d)~~[(e)]~~ In addition to any previous notice required under KRS 304.17A-607(1)(j), and to facilitate expeditious handling of a request for external review of an adverse determination or a coverage denial, an insurer or agent that denies, limits, reduces, or terminates coverage for a treatment, procedure, drug, or device for a covered person shall provide the covered person, authorized person, or provider acting on behalf of the covered person with an internal appeal determination letter that shall include:

1. A statement of the specific medical and scientific reasons for denying coverage or identifying that provision of the schedule of benefits or exclusions that demonstrates that coverage is not available;

2. The state of licensure, medical license number, and the title of the person making the decision;

3. Except for retrospective review, a description of alternative benefits, services, or supplies covered by the health benefit plan, if any; and

4. Instructions for initiating an external review of an adverse determination, or filing a request for review with the department if a coverage denial is upheld by the insurer on internal appeal.

(4) ~~[(3)]~~ ***(a)*** The department shall establish and maintain a system for receiving and reviewing requests for review of coverage denials from covered persons, authorized persons, and providers.

(b) For purposes of this subsection, "coverage denials" shall not include an adverse determination as defined in KRS 304.17A-600 or subsequent denials arising from an adverse determination.

(c) ~~[(a)]~~ On receipt of a written request for review of a coverage denial from a covered person, authorized person, or provider, the department shall notify the insurer which issued the denial of the request for review and shall call for the insurer to respond to the department regarding the request for review within ten (10) business days of receipt of notice to the insurer.

(d) ~~[(b)]~~ Within ten (10) business days of receiving the notice of the request for review from the department, the insurer shall provide to the department the following information:

1. Confirmation as to whether the person who received or sought the health service for which coverage was denied was a covered person under a health benefit plan issued by the insurer on the date the service was sought or denied;

2. Confirmation as to whether the covered person, authorized person, or provider has exhausted his or her rights under the insurer's appeal process under this section; and

3. The reason for the coverage denial, including the specific limitation or exclusion of the health benefit plan demonstrating that coverage is not available.

(e) ~~[(c)]~~ In addition to the information described in paragraph ***(d)*** ~~[(b)]~~ of this subsection, the insurer and the covered person, authorized person, or provider shall provide to the department any information requested by the department that is germane to its review.

(f) ~~[(d)]~~ ***1.*** On the receipt of the information described in paragraphs ***(d)*** ~~[(b)]~~ and ***(e)*** ~~[(c)]~~ of this subsection, unless the department is not able to do so because making a determination requires resolution of a medical issue, it shall determine whether the service, treatment, drug, or device is specifically limited or excluded under the terms of the covered person's health benefit plan.

2. If the department determines that the treatment, service, drug, or device is not specifically limited or excluded, it shall so notify the insurer, and the insurer shall either cover the service, or afford the covered person an opportunity for external review under KRS 304.17A-621, 304.17A-623, and 304.17A-625, where the conditions precedent to the review are present.

3. If the department notifies the insurer that the treatment, service, drug, or device is specifically limited or excluded in the health benefit plan, the insurer is not required to cover the service or afford the covered person an external review.

(g) ~~[(e)]~~ An insurer shall be required to cover the treatment, service, drug, or device that was denied or provide notification of the right to external review in accordance with paragraph ***(f)*** ~~[(d)]~~ of this subsection whether the covered person has disenrolled or remains enrolled with the insurer.

(h) ~~[(f)]~~ If the covered person has disenrolled with the insurer, the insurer shall only be required to provide the treatment, service, drug, or device that was denied for a period not to exceed thirty (30) days~~[,]~~ or provide the covered person the opportunity for external review.

➔Section 8. KRS 304.17A-623 is amended to read as follows:

(1) ***(a)*** Every insurer shall have an external review process to be utilized by the insurer or its designee, consistent with this section and which shall be disclosed to covered persons in accordance with KRS 304.17A-505(1)(g).

(b) An insurer, its designee, or agent shall disclose the availability of the external review process to the covered person in the insured's timely notice of an adverse determination or notice of a coverage denial as set forth in KRS 304.17A-607(1)(j) and in the denial letter required in KRS 304.17A-617(1) and ***(3)(d)***~~[(2)(e)]~~.

(c) For purposes of this section**,** "coverage denial" means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the covered person's health benefit plan.

(2) A covered person, an authorized person, or a provider acting on behalf of and with the consent of the covered person, may request an external review of an adverse determination rendered by an insurer, its designee, or agent.

(3) ***Except as provided in Section 1 of this Act,*** the insurer shall provide for an external review of an adverse determination if the following criteria are met:

(a) The insurer, its designee, or agent has rendered an adverse determination;

(b) The covered person has completed the insurer's internal appeal process, or the insurer has failed to make a timely determination or notification as set forth in KRS 304.17A-619(2). The insurer and the covered person may**,** however, jointly agree to waive the internal appeal requirement;

(c) The covered person was enrolled in the health benefit plan on the date of service or, if a prospective denial, the covered person was enrolled and eligible to receive covered benefits under the health benefit plan on the date the proposed service was requested; and

(d) The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.

(4) The covered person, an authorized person, or a provider with consent of the covered person shall submit a request for external review to the insurer within sixty (60) days, except as set forth in KRS 304.17A-619(1), of receiving notice that an adverse determination has been timely rendered under the insurer's internal appeal process. As part of the request, the covered person shall provide to the insurer or its designee written consent authorizing the independent review entity to obtain all necessary medical records from both the insurer and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

(5) The covered person shall be assessed a one (1) time filing fee of twenty-five dollars ($25) to be paid to the independent review entity and which may be waived if the independent review entity determines that the fee creates a financial hardship on the covered person. The fee shall be refunded if the independent review entity finds in favor of the covered person.

(6) A covered person shall not be afforded an external review of an adverse determination if:

(a) The subject of the covered person's adverse determination has previously gone through the external review process and the independent review entity found in favor of the insurer; and

(b) No relevant new clinical information has been submitted to the insurer since the independent review entity found in favor of the insurer.

(7) The department shall establish a system for each insurer to be assigned an independent review entity for external reviews. The system established by the department shall be prospective and shall require insurers to utilize independent review entities on a rotating basis so that an insurer does not have the same independent review entity for two (2) consecutive external reviews. The department shall contract with no less than two (2) independent review entities.

(8) (a) If a dispute arises between an insurer and a covered person regarding the covered person's right to an external review, the covered person may file a complaint with the department. Within five (5) days of receipt of the complaint, the department shall render a decision and may direct the insurer to submit the dispute to an independent review entity for an external review if it finds:

1. The dispute involves denial of coverage based on medical necessity or the service being experimental or investigational; and

2. All of the requirements of subsection (3) of this section have been met.

(b) The complaint process established in this section shall be separate and distinct from, and shall in no way limit other grievance or complaint processes available to consumers under other provisions of the KRS or duly promulgated administrative regulations. This complaint process shall not limit, alter, or supplant the mechanisms for appealing coverage denials established in KRS 304.17A-617.

(9) The external review process shall be confidential and shall not be subject to KRS 61.805 to 61.850 and KRS 61.870 to 61.884.

(10) External reviews shall be conducted in an expedited manner by the independent review entity if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

(a) Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of a bodily organ or part.

(11) Requests for expedited external review, shall be forwarded by the insurer to the independent review entity within twenty-four (24) hours of receipt by the insurer.

(12) For expedited external review, a determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the insurer. An extension of up to twenty-four (24) hours may be allowed if the covered person and the insurer or its designee agree. The insurer or its designee shall provide notice to the independent review entity and to the covered person, by same-day communication, that the adverse determination has been assigned to an independent review entity for expedited review.

(13) External reviews which are not expedited shall be conducted by the independent review entity and a determination made within twenty-one (21) calendar days from the receipt of all information required from the insurer. An extension of up to fourteen (14) calendar days may be allowed if the covered person and the insurer are in agreement.

➔Section 9. KRS 205.522 is amended to read as follows:

(1) The Department for Medicaid Services and any managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the provisions of ***Sections 1 and 2 of this Act and*** KRS 304.17A-167, 304.17A-235, 304.17A-257, 304.17A-259, 304.17A-515, 304.17A-580, 304.17A-600, 304.17A-603, 304.17A-607, and 304.17A-740 to 304.17A-743, as applicable.

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

➔Section 10. KRS 205.6485 is amended to read as follows:

(1) The Cabinet for Health and Family Services shall prepare a state child health plan meeting the requirements of Title XXI of the Federal Social Security Act, for submission to the Secretary of the United States Department of Health and Human Services within such time as will permit the state to receive the maximum amounts of federal matching funds available under Title XXI. The cabinet shall, by administrative regulation promulgated in accordance with KRS Chapter 13A, establish the following:

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

(b) The schedule of benefits to be covered by the Kentucky Children's Health Insurance Program, which shall include preventive services, vision services including glasses, and dental services including at least sealants, extractions, and fillings, and which shall be at least equivalent to one (1) of the following:

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

2. A mid-range health benefit coverage plan that is offered and generally available to state employees; or

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

(c) The premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program with provisions for the payment of premium contributions by families of children eligible for coverage by the program based upon a sliding scale relating to family income. Premium contributions shall be based on a six (6) month period not to exceed:

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

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

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

(d) There shall be no copayments for services provided under the Kentucky Children's Health Insurance Program; and

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

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

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

(4) The Kentucky Children's Health Insurance Plan shall comply with Sections 1 and 2 of this Act.

➔Section 11. KRS 164.2871 is amended to read as follows:

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

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

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

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

(a) Conform to the requirements of Subtitle 32 of KRS Chapter 304***;*** and~~[shall]~~

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

(5) A self-insured employer group health plan provided by the governing board of a state postsecondary education institution to its employees shall comply with Sections 1 and 2 of this Act.

➔Section 12. KRS 18A.225 is amended to read as follows:

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

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

2. Any certified or classified employee of a local board of education;

3. Any elected member of a local board of education;

4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(4)(c), unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

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

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

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

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

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

insurance program. Health insurance coverage provided to state employees under this section shall, at a minimum, contain the same benefits as provided under Kentucky Kare Standard as of January 1, 1994, and shall include a mail-order drug option as provided in subsection (13) of this section. All employees and other persons for whom the health care coverage is provided or made available shall annually be given an option to elect health care coverage through a self-funded plan offered by the Commonwealth or, if a self-funded plan is not available, from a list of coverage options determined by the competitive bid process under the provisions of KRS 45A.080, 45A.085, and 45A.090 and made available during annual open enrollment.

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

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

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

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

(f) If any agency participating in the state-sponsored employee health insurance program for its active employees terminates participation and there is a state appropriation for the employer's contribution for active employees' health insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

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

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

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

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

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

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

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

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

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

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

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

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or the secretary's designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

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

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

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

(13) (a) The policies of health insurance coverage procured under subsection (2) of this section shall include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed

under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

(22) Any fully insured health benefit plan or self-insured plan issued or renewed~~[on or after June 29, 2021,]~~ to public employees pursuant to this section shall comply with:

(a) KRS 304.12-237;

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

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

(d) KRS 205.593;

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

(f) KRS 304.14-135;

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

(h) KRS 304.99-123;

(i) KRS 304.17A-138;~~[and]~~

(j) ***KRS 304.17A-148;***

(k) Sections 1 and 2 of this Act; and

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

~~[(23) Any fully insured health benefit plan or self-insured plan issued or renewed on or after January 1, 2022, to public employees pursuant to this section shall comply with KRS 304.17A-148.]~~

➔Section 13. This Act shall apply to health plans delivered, issued for delivery, or renewed on or after the effective date of Sections 1 to 12 of this Act.

➔Section 14. If the Cabinet for Health and Family Services determines that a waiver or other authorization from a federal agency is necessary to implement Sections 9 or 10 of this Act for any reason, including the loss of federal funds, the cabinet shall, within 90 days of the effective date of this section, request the waiver or authorization, and may only delay implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 15. Sections 1 to 12 of this Act take effect January 1, 2023.

Signed by Governor March 17, 2022.