

1 AN ACT relating to coverage for certain abortion-related medical expenses  
2 mandated by law.

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

4 ➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304  
5 IS CREATED TO READ AS FOLLOWS:

6 *(1) Notwithstanding any provision of law to the contrary, a health benefit plan shall*  
7 *provide coverage to an insured for any medical expenses resulting from the*  
8 *requirements mandated in Sections (2), (3), and (9) of 17 RS SB 5/GA (2017 Ky.*  
9 *Acts Ch. 5).*

10 *(2) Coverage required by this section shall not be subject to any cost-sharing*  
11 *requirements, benefit maximums, or waiting periods.*

12 ➔SECTION 2. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO  
13 READ AS FOLLOWS:

14 *(1) Notwithstanding any provision of law to the contrary, the Department for*  
15 *Medicaid Services or a managed care organization contracted to provide*  
16 *Medicaid services shall provide coverage to an insured for any medical expenses*  
17 *resulting from the requirements mandated in Sections (2), (3), and (9) of 17 RS*  
18 *SB 5/GA (2017 Ky. Acts Ch. 5).*

19 *(2) Coverage required by this section shall not be subject to any cost-sharing*  
20 *requirements, benefit maximums, or waiting periods.*

21 ➔Section 3. KRS 18A.225 is amended to read as follows:

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

23 1. Any person, including an elected public official, who is regularly  
24 employed by any department, office, board, agency, or branch of state  
25 government; or by a public postsecondary educational institution; or by  
26 any city, urban-county, charter county, county, or consolidated local  
27 government, whose legislative body has opted to participate in the state-

- 1 sponsored health insurance program pursuant to KRS 79.080; and who  
2 is either a contributing member to any one (1) of the retirement systems  
3 administered by the state, including but not limited to the Kentucky  
4 Retirement Systems, Kentucky Teachers' Retirement System, the  
5 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is  
6 receiving a contractual contribution from the state toward a retirement  
7 plan; or, in the case of a public postsecondary education institution, is an  
8 individual participating in an optional retirement plan authorized by  
9 KRS 161.567;
- 10 2. Any certified or classified employee of a local board of education;
- 11 3. Any elected member of a local board of education;
- 12 4. Any person who is a present or future recipient of a retirement  
13 allowance from the Kentucky Retirement Systems, Kentucky Teachers'  
14 Retirement System, the Legislators' Retirement Plan, the Judicial  
15 Retirement Plan, or the Kentucky Community and Technical College  
16 System's optional retirement plan authorized by KRS 161.567, except  
17 that a person who is receiving a retirement allowance and who is age  
18 sixty-five (65) or older shall not be included, with the exception of  
19 persons covered under KRS 61.702(4)(c), unless he or she is actively  
20 employed pursuant to subparagraph 1. of this paragraph; and
- 21 5. Any eligible dependents and beneficiaries of participating employees  
22 and retirees who are entitled to participate in the state-sponsored health  
23 insurance program;
- 24 (b) The term "health benefit plan" for the purposes of this section means a health  
25 benefit plan as defined in KRS 304.17A-005;
- 26 (c) The term "insurer" for the purposes of this section means an insurer as defined  
27 in KRS 304.17A-005; and

- 1 (d) The term "managed care plan" for the purposes of this section means a  
2 managed care plan as defined in KRS 304.17A-500.
- 3 (2) (a) The secretary of the Finance and Administration Cabinet, upon the  
4 recommendation of the secretary of the Personnel Cabinet, shall procure, in  
5 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,  
6 from one (1) or more insurers authorized to do business in this state, a group  
7 health benefit plan that may include but not be limited to health maintenance  
8 organization (HMO), preferred provider organization (PPO), point of service  
9 (POS), and exclusive provider organization (EPO) benefit plans encompassing  
10 all or any class or classes of employees. With the exception of employers  
11 governed by the provisions of KRS Chapters 16, 18A, and 151B, all  
12 employers of any class of employees or former employees shall enter into a  
13 contract with the Personnel Cabinet prior to including that group in the state  
14 health insurance group. The contracts shall include but not be limited to  
15 designating the entity responsible for filing any federal forms, adoption of  
16 policies required for proper plan administration, acceptance of the contractual  
17 provisions with health insurance carriers or third-party administrators, and  
18 adoption of the payment and reimbursement methods necessary for efficient  
19 administration of the health insurance program. Health insurance coverage  
20 provided to state employees under this section shall, at a minimum, contain  
21 the same benefits as provided under Kentucky Kare Standard as of January 1,  
22 1994, and shall include a mail-order drug option as provided in subsection  
23 (13) of this section. All employees and other persons for whom the health care  
24 coverage is provided or made available shall annually be given an option to  
25 elect health care coverage through a self-funded plan offered by the  
26 Commonwealth or, if a self-funded plan is not available, from a list of  
27 coverage options determined by the competitive bid process under the

1 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available  
2 during annual open enrollment.

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

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

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

24 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities  
25 for timely analysis of data received from carriers and, to the extent possible,  
26 provide in the request-for-proposal specifics relating to data requirements,  
27 electronic reporting, and penalties for noncompliance. The Commonwealth

1 shall own the enrollment, claims, and utilization data provided by each carrier  
2 and shall develop methods to protect the confidentiality of the individual. The  
3 Personnel Cabinet shall include in the October annual report submitted  
4 pursuant to the provisions of KRS 18A.226 to the Governor, the General  
5 Assembly, and the Chief Justice of the Supreme Court, an analysis of the  
6 financial stability of the program, which shall include but not be limited to  
7 loss ratios, methods of risk adjustment, measurements of carrier quality of  
8 service, prescription coverage and cost management, and statutorily required  
9 mandates. If state self-insurance was available as a carrier option, the report  
10 also shall provide a detailed financial analysis of the self-insurance fund  
11 including but not limited to loss ratios, reserves, and reinsurance agreements.

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

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

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

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

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

- 1 otherwise;
- 2 (b) Wholly from funds contributed by any department, board, agency, public  
3 postsecondary education institution, or branch of state, city, urban-county,  
4 charter county, county, or consolidated local government; or
- 5 (c) Partly from each, except that any premium due for health care coverage or  
6 dental coverage, if any, in excess of the premium amount contributed by any  
7 department, board, agency, postsecondary education institution, or branch of  
8 state, city, urban-county, charter county, county, or consolidated local  
9 government for any other health care coverage shall be paid by the employee.
- 10 (4) If an employee moves his place of residence or employment out of the service area  
11 of an insurer offering a managed health care plan, under which he has elected  
12 coverage, into either the service area of another managed health care plan or into an  
13 area of the Commonwealth not within a managed health care plan service area, the  
14 employee shall be given an option, at the time of the move or transfer, to change his  
15 or her coverage to another health benefit plan.
- 16 (5) No payment of premium by any department, board, agency, public postsecondary  
17 educational institution, or branch of state, city, urban-county, charter county,  
18 county, or consolidated local government shall constitute compensation to an  
19 insured employee for the purposes of any statute fixing or limiting the  
20 compensation of such an employee. Any premium or other expense incurred by any  
21 department, board, agency, public postsecondary educational institution, or branch  
22 of state, city, urban-county, charter county, county, or consolidated local  
23 government shall be considered a proper cost of administration.
- 24 (6) The policy or policies may contain the provisions with respect to the class or classes  
25 of employees covered, amounts of insurance or coverage for designated classes or  
26 groups of employees, policy options, terms of eligibility, and continuation of  
27 insurance or coverage after retirement.

- 1 (7) Group rates under this section shall be made available to the disabled child of an  
2 employee regardless of the child's age if the entire premium for the disabled child's  
3 coverage is paid by the state employee. A child shall be considered disabled if he  
4 has been determined to be eligible for federal Social Security disability benefits.
- 5 (8) The health care contract or contracts for employees shall be entered into for a period  
6 of not less than one (1) year.
- 7 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of  
8 State Health Insurance Subscribers to advise the secretary or his designee regarding  
9 the state-sponsored health insurance program for employees. The secretary shall  
10 appoint, from a list of names submitted by appointing authorities, members  
11 representing school districts from each of the seven (7) Supreme Court districts,  
12 members representing state government from each of the seven (7) Supreme Court  
13 districts, two (2) members representing retirees under age sixty-five (65), one (1)  
14 member representing local health departments, two (2) members representing the  
15 Kentucky Teachers' Retirement System, and three (3) members at large. The  
16 secretary shall also appoint two (2) members from a list of five (5) names submitted  
17 by the Kentucky Education Association, two (2) members from a list of five (5)  
18 names submitted by the largest state employee organization of nonschool state  
19 employees, two (2) members from a list of five (5) names submitted by the  
20 Kentucky Association of Counties, two (2) members from a list of five (5) names  
21 submitted by the Kentucky League of Cities, and two (2) members from a list of  
22 names consisting of five (5) names submitted by each state employee organization  
23 that has two thousand (2,000) or more members on state payroll deduction. The  
24 advisory committee shall be appointed in January of each year and shall meet  
25 quarterly.
- 26 (10) ~~The~~ Notwithstanding any other provision of law to the contrary, the policy or  
27 policies provided to employees pursuant to this section shall not provide coverage

1 for obtaining or performing an abortion, nor shall any state funds be used for the  
2 purpose of obtaining or performing an abortion on behalf of employees or their  
3 dependents, except each policy shall provide coverage in accordance with Section  
4 1 of this Act.

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

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

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

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

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

- 1 (14) The policy or policies provided to state employees or their dependents pursuant to  
2 this section shall provide coverage for obtaining a hearing aid and acquiring hearing  
3 aid-related services for insured individuals under eighteen (18) years of age, subject  
4 to a cap of one thousand four hundred dollars (\$1,400) every thirty-six (36) months  
5 pursuant to KRS 304.17A-132.
- 6 (15) Any policy provided to state employees or their dependents pursuant to this section  
7 shall provide coverage for the diagnosis and treatment of autism spectrum disorders  
8 consistent with KRS 304.17A-142.
- 9 (16) Any policy provided to state employees or their dependents pursuant to this section  
10 shall provide coverage for obtaining amino acid-based elemental formula pursuant  
11 to KRS 304.17A-258.
- 12 (17) If a state employee's residence and place of employment are in the same county, and  
13 if the hospital located within that county does not offer surgical services, intensive  
14 care services, obstetrical services, level II neonatal services, diagnostic cardiac  
15 catheterization services, and magnetic resonance imaging services, the employee  
16 may select a plan available in a contiguous county that does provide those services,  
17 and the state contribution for the plan shall be the amount available in the county  
18 where the plan selected is located.
- 19 (18) If a state employee's residence and place of employment are each located in counties  
20 in which the hospitals do not offer surgical services, intensive care services,  
21 obstetrical services, level II neonatal services, diagnostic cardiac catheterization  
22 services, and magnetic resonance imaging services, the employee may select a plan  
23 available in a county contiguous to the county of residence that does provide those  
24 services, and the state contribution for the plan shall be the amount available in the  
25 county where the plan selected is located.
- 26 (19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and  
27 in the best interests of the state group to allow any carrier bidding to offer health

1 care coverage under this section to submit bids that may vary county by county or  
2 by larger geographic areas.

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

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

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

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

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

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

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

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

4 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or  
5 after July 12, 2006, to public employees pursuant to this section shall comply with  
6 the provisions of KRS 304.17A-270 and 304.17A-525.

7 (23) Any full insured health benefit plan or self insured plan issued or renewed on or  
8 after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to  
9 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to  
10 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to  
11 uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641  
12 pertaining to emergency medical care, KRS 304.99-123, and any administrative  
13 regulations promulgated thereunder.

14 ➔Section 4. KRS 205.010 is amended to read as follows:

15 As used in this chapter, unless the context requires otherwise:

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

17 (2) "Secretary" means the secretary for health and family services or his authorized  
18 representative;

19 (3) "Public assistance" means money grants, assistance in kind, or services to or for the  
20 benefit of needy aged, needy blind, needy permanently and totally disabled persons,  
21 needy children, or persons with whom a needy child lives or a family containing a  
22 combination of these categories, except that the term shall not be construed to  
23 permit the granting of financial aid where the purpose of such aid is to obtain an  
24 abortion, **except as otherwise provided in Section 2 of this Act.** For purposes of this  
25 section and KRS 205.560, "abortion" means an act, procedure, device, or  
26 prescription administered or prescribed for a pregnant woman by any person,  
27 including the pregnant woman herself, producing premature expulsion of the fetus.

- 1           Abortion does not include an induced premature birth intended to produce a live  
2           viable child;
- 3       (4) "Needy child" means a child who has been deprived of parental support by reasons  
4           prescribed by regulations within the scope of Title IV of the Social Security Act, its  
5           amendments, and federal regulations and who does not have otherwise provided for  
6           him a subsistence compatible with decency and health;
- 7       (5) "Parent," in addition to biological or adoptive parent, shall include stepparent;
- 8       (6) "Needy aged" means a person who has attained the age of sixty-five (65) and who is  
9           unable to provide for himself and who does not have otherwise provided for him a  
10          subsistence compatible with decency and health;
- 11       (7) "Needy blind" means a person who has no vision or whose vision is so defective as  
12          to prevent the performance of ordinary activities for which eyesight is essential and  
13          who is unable to provide for himself and who does not have otherwise provided for  
14          him a subsistence compatible with decency and health;
- 15       (8) "Person with whom a needy child lives" means the individual prescribed by  
16          regulation, with whom such child is living in a place of residence maintained by  
17          such individual by himself or together with one (1) or more other persons;
- 18       (9) "Needy permanently and totally disabled" means a person eighteen (18) years of age  
19          or older and who has a permanent physical or mental impairment, disease, or loss  
20          that substantially precludes him from engaging in useful occupations within his  
21          competence and who is unable to provide for himself and who does not have  
22          otherwise provided for him a subsistence compatible with decency and health;
- 23       (10) "Private institution" means any establishment or place other than a public institution  
24          operated or maintained by any individual, association, corporation, or other  
25          organization which provides a group living arrangement for four (4) or more  
26          individuals, who are cared for and maintained in residence for compensation or  
27          otherwise;

- 1 (11) "Public institution" means any establishment or place which is the responsibility of  
2 and administered by the state or any political subdivision thereof providing a group  
3 living arrangement in which one (1) or more individuals are cared for and  
4 maintained in residence;
- 5 (12) "Public medical institution" means any public institution the primary purpose of  
6 which is to furnish hospital care and medical treatment;
- 7 (13) "Person determined to be potentially responsible" means any person who:  
8 (a) Is not aged, blind, disabled, incapacitated, or needed in the home:  
9 1. Because of the illness or incapacity of a member of the family; or  
10 2. Because of children in the home under the age of six (6); or  
11 (b) Volunteers for such determination;
- 12 (14) Nothing in this section shall be deemed to deprive a woman of all appropriate  
13 medical care necessary to prevent her physical death;
- 14 (15) "Adult day-care center" means any adult care facility which provides part-time care,  
15 day or night, but less than twenty-four (24) hours, to at least four (4) adults not  
16 related to the operator of the adult care facility by blood, marriage, or adoption.
- 17 ➔Section 5. KRS 205.560 is amended to read as follows:
- 18 (1) The scope of medical care for which the Cabinet for Health and Family Services  
19 undertakes to pay shall be designated and limited by regulations promulgated by the  
20 cabinet, pursuant to the provisions in this section. Within the limitations of any  
21 appropriation therefor, the provision of complete upper and lower dentures to  
22 recipients of Medical Assistance Program benefits who have their teeth removed by  
23 a dentist resulting in the total absence of teeth shall be a mandatory class in the  
24 scope of medical care. Payment to a dentist of any Medical Assistance Program  
25 benefits for complete upper and lower dentures shall only be provided on the  
26 condition of a preauthorized agreement between an authorized representative of the  
27 Medical Assistance Program and the dentist prior to the removal of the teeth. The

1 selection of another class or other classes of medical care shall be recommended by  
2 the council to the secretary for health and family services after taking into  
3 consideration, among other things, the amount of federal and state funds available,  
4 the most essential needs of recipients, and the meeting of such need on a basis  
5 insuring the greatest amount of medical care as defined in KRS 205.510 consonant  
6 with the funds available, including but not limited to the following categories,  
7 except where the aid is for the purpose of obtaining an abortion, *except as*  
8 *otherwise provided in Section 2 of this Act:*

- 9 (a) Hospital care, including drugs, and medical supplies and services during any  
10 period of actual hospitalization;
- 11 (b) Nursing-home care, including medical supplies and services, and drugs during  
12 confinement therein on prescription of a physician, dentist, or podiatrist;
- 13 (c) Drugs, nursing care, medical supplies, and services during the time when a  
14 recipient is not in a hospital but is under treatment and on the prescription of a  
15 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall  
16 include products for the treatment of inborn errors of metabolism or genetic,  
17 gastrointestinal, and food allergic conditions, consisting of therapeutic food,  
18 formulas, supplements, amino acid-based elemental formula, or low-protein  
19 modified food products that are medically indicated for therapeutic treatment  
20 and are administered under the direction of a physician, and include but are  
21 not limited to the following conditions:
- 22 1. Phenylketonuria;
  - 23 2. Hyperphenylalaninemia;
  - 24 3. Tyrosinemia (types I, II, and III);
  - 25 4. Maple syrup urine disease;
  - 26 5. A-ketoacid dehydrogenase deficiency;
  - 27 6. Isovaleryl-CoA dehydrogenase deficiency;

- 1           7.    3-methylcrotonyl-CoA carboxylase deficiency;
- 2           8.    3-methylglutaconyl-CoA hydratase deficiency;
- 3           9.    3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase
- 4           deficiency);
- 5           10.   B-ketothiolase deficiency;
- 6           11.   Homocystinuria;
- 7           12.   Glutaric aciduria (types I and II);
- 8           13.   Lysinuric protein intolerance;
- 9           14.   Non-ketotic hyperglycinemia;
- 10          15.   Propionic acidemia;
- 11          16.   Gyrate atrophy;
- 12          17.   Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 13          18.   Carbamoyl phosphate synthetase deficiency;
- 14          19.   Ornithine carbamoyl transferase deficiency;
- 15          20.   Citrullinemia;
- 16          21.   Arginosuccinic aciduria;
- 17          22.   Methylmalonic acidemia;
- 18          23.   Argininemia;
- 19          24.   Food protein allergies;
- 20          25.   Food protein-induced enterocolitis syndrome;
- 21          26.   Eosinophilic disorders; and
- 22          27.   Short bowel syndrome;
- 23          (d)   Physician, podiatric, and dental services;
- 24          (e)   Optometric services for all age groups shall be limited to prescription services,
- 25           services to frames and lenses, and diagnostic services provided by an
- 26           optometrist, to the extent the optometrist is licensed to perform the services
- 27           and to the extent the services are covered in the ophthalmologist portion of the

- 1 physician's program. Eyeglasses shall be provided only to children under age  
2 twenty-one (21);
- 3 (f) Drugs on the prescription of a physician used to prevent the rejection of  
4 transplanted organs if the patient is indigent;
- 5 (g) Nonprofit neighborhood health organizations or clinics where some or all of  
6 the medical services are provided by licensed registered nurses or by advanced  
7 medical students presently enrolled in a medical school accredited by the  
8 Association of American Medical Colleges and where the students or licensed  
9 registered nurses are under the direct supervision of a licensed physician who  
10 rotates his services in this supervisory capacity between two (2) or more of the  
11 nonprofit neighborhood health organizations or clinics specified in this  
12 paragraph;
- 13 (h) Services provided by health-care delivery networks as defined in KRS  
14 216.900;
- 15 (i) Services provided by midlevel health-care practitioners as defined in KRS  
16 216.900; and
- 17 (j) Smoking cessation treatment interventions or programs prescribed by a  
18 physician, advanced practice registered nurse, physician assistant, or dentist,  
19 including but not limited to counseling, telephone counseling through a  
20 quitline, recommendations to the recipient that smoking should be  
21 discontinued, and prescription and over-the-counter medications and nicotine  
22 replacement therapy approved by the United States Food and Drug  
23 Administration for smoking cessation.
- 24 (2) Payments for hospital care, nursing-home care, and drugs or other medical,  
25 ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount  
26 of the payment to the cost of providing the services or supplies. It shall be one (1) of  
27 the functions of the council to make recommendations to the Cabinet for Health and

1 Family Services with respect to the bases for payment. In determining the rates of  
2 reimbursement for long-term-care facilities participating in the Medical Assistance  
3 Program, the Cabinet for Health and Family Services shall, to the extent permitted  
4 by federal law, not allow the following items to be considered as a cost to the  
5 facility for purposes of reimbursement:

6 (a) Motor vehicles that are not owned by the facility, including motor vehicles  
7 that are registered or owned by the facility but used primarily by the owner or  
8 family members thereof;

9 (b) The cost of motor vehicles, including vans or trucks, used for facility business  
10 shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted  
11 annually for inflation according to the increase in the consumer price index-u  
12 for the most recent twelve (12) month period, as determined by the United  
13 States Department of Labor. Medically equipped motor vehicles, vans, or  
14 trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation.  
15 Costs exceeding this limit shall not be reimbursable and shall be borne by the  
16 facility. Costs for additional motor vehicles, not to exceed a total of three (3)  
17 per facility, may be approved by the Cabinet for Health and Family Services if  
18 the facility demonstrates that each additional vehicle is necessary for the  
19 operation of the facility as required by regulations of the cabinet;

20 (c) Salaries paid to immediate family members of the owner or administrator, or  
21 both, of a facility, to the extent that services are not actually performed and are  
22 not a necessary function as required by regulation of the cabinet for the  
23 operation of the facility. The facility shall keep a record of all work actually  
24 performed by family members;

25 (d) The cost of contracts, loans, or other payments made by the facility to owners,  
26 administrators, or both, unless the payments are for services which would  
27 otherwise be necessary to the operation of the facility and the services are

- 1 required by regulations of the Cabinet for Health and Family Services. Any  
2 other payments shall be deemed part of the owner's compensation in  
3 accordance with maximum limits established by regulations of the Cabinet for  
4 Health and Family Services. Interest paid to the facility for loans made to a  
5 third party may be used to offset allowable interest claimed by the facility;
- 6 (e) Private club memberships for owners or administrators, travel expenses for  
7 trips outside the state for owners or administrators, and other indirect  
8 payments made to the owner, unless the payments are deemed part of the  
9 owner's compensation in accordance with maximum limits established by  
10 regulations of the Cabinet for Health and Family Services; and
- 11 (f) Payments made to related organizations supplying the facility with goods or  
12 services shall be limited to the actual cost of the goods or services to the  
13 related organization, unless it can be demonstrated that no relationship  
14 between the facility and the supplier exists. A relationship shall be considered  
15 to exist when an individual, including brothers, sisters, father, mother, aunts,  
16 uncles, and in-laws, possesses a total of five percent (5%) or more of  
17 ownership equity in the facility and the supplying business. An exception to  
18 the relationship shall exist if fifty-one percent (51%) or more of the supplier's  
19 business activity of the type carried on with the facility is transacted with  
20 persons and organizations other than the facility and its related organizations.
- 21 (3) No vendor payment shall be made unless the class and type of medical care  
22 rendered and the cost basis therefor has first been designated by regulation.
- 23 (4) The rules and regulations of the Cabinet for Health and Family Services shall  
24 require that a written statement, including the required opinion of a physician, shall  
25 accompany any claim for reimbursement for induced premature births. This  
26 statement shall indicate the procedures used in providing the medical services.
- 27 (5) The range of medical care benefit standards provided and the quality and quantity

1 standards and the methods for determining cost formulae for vendor payments  
2 within each category of public assistance and other recipients shall be uniform for  
3 the entire state, and shall be designated by regulation promulgated within the  
4 limitations established by the Social Security Act and federal regulations. It shall  
5 not be necessary that the amount of payments for units of services be uniform for  
6 the entire state but amounts may vary from county to county and from city to city, as  
7 well as among hospitals, based on the prevailing cost of medical care in each locale  
8 and other local economic and geographic conditions, except that insofar as allowed  
9 by applicable federal law and regulation, the maximum amounts reimbursable for  
10 similar services rendered by physicians within the same specialty of medical  
11 practice shall not vary according to the physician's place of residence or place of  
12 practice, as long as the place of practice is within the boundaries of the state.

13 (6) Nothing in this section shall be deemed to deprive a woman of all appropriate  
14 medical care necessary to prevent her physical death.

15 (7) To the extent permitted by federal law, no medical assistance recipient shall be  
16 recertified as qualifying for a level of long-term care below the recipient's current  
17 level, unless the recertification includes a physical examination conducted by a  
18 physician licensed pursuant to KRS Chapter 311 or by an advanced practice  
19 registered nurse licensed pursuant to KRS Chapter 314 and acting under the  
20 physician's supervision.

21 (8) If payments made to community mental health centers, established pursuant to KRS  
22 Chapter 210, for services provided to the intellectually disabled exceed the actual  
23 cost of providing the service, the balance of the payments shall be used solely for  
24 the provision of other services to the intellectually disabled through community  
25 mental health centers.

26 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to  
27 recipients of medical assistance under Title XIX of the Social Security Act on July

1           15, 1986, shall deny admission of a person to a bed certified for reimbursement  
2           under the provisions of the Medical Assistance Program solely on the basis of the  
3           person's paying status as a Medicaid recipient. No person shall be removed or  
4           discharged from any facility solely because they became eligible for participation in  
5           the Medical Assistance Program, unless the facility can demonstrate the resident or  
6           the resident's responsible party was fully notified in writing that the resident was  
7           being admitted to a bed not certified for Medicaid reimbursement. No facility may  
8           decertify a bed occupied by a Medicaid recipient or may decertify a bed that is  
9           occupied by a resident who has made application for medical assistance.

10       (10) Family-practice physicians practicing in geographic areas with no more than one (1)  
11           primary-care physician per five thousand (5,000) population, as reported by the  
12           United States Department of Health and Human Services, shall be reimbursed one  
13           hundred twenty-five percent (125%) of the standard reimbursement rate for  
14           physician services.

15       (11) The Cabinet for Health and Family Services shall make payments under the Medical  
16           Assistance program for services which are within the lawful scope of practice of a  
17           chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical  
18           Assistance Program pays for the same services provided by a physician.

19       (12) (a) The Medical Assistance Program shall use the appropriate form and  
20           guidelines for enrolling those providers applying for participation in the  
21           Medical Assistance Program, including those licensed and regulated under  
22           KRS Chapters 311, 312, 314, 315, and 320, any facility required to be  
23           licensed pursuant to KRS Chapter 216B, and any other health care practitioner  
24           or facility as determined by the Department for Medicaid Services through an  
25           administrative regulation promulgated under KRS Chapter 13A. A Medicaid  
26           managed care organization shall use the forms and guidelines established  
27           under KRS 304.17A-545(5) to credential a provider. For any provider who

1 contracts with and is credentialed by a Medicaid managed care organization  
2 prior to enrollment, the cabinet shall complete the enrollment process and  
3 deny, or approve and issue a Provider Identification Number (PID) within  
4 fifteen (15) business days from the time all necessary completed enrollment  
5 forms have been submitted and all outstanding accounts receivable have been  
6 satisfied.

7 (b) Within forty-five (45) days of receiving a correct and complete provider  
8 application, the Department for Medicaid Services shall complete the  
9 enrollment process by either denying or approving and issuing a Provider  
10 Identification Number (PID) for a behavioral health provider who provides  
11 substance use disorder services, unless the department notifies the provider  
12 that additional time is needed to render a decision for resolution of an issue or  
13 dispute.

14 (c) Within forty-five (45) days of receipt of a correct and complete application for  
15 credentialing by a behavioral health provider providing substance use disorder  
16 services, a Medicaid managed care organization shall complete its contracting  
17 and credentialing process, unless the Medicaid managed care organization  
18 notifies the provider that additional time is needed to render a decision. If  
19 additional time is needed, the Medicaid managed care organization shall not  
20 take any longer than ninety (90) days from receipt of the credentialing  
21 application to deny or approve and contract with the provider.

22 (d) A Medicaid managed care organization shall adjudicate any clean claims  
23 submitted for a substance use disorder service from an enrolled and  
24 credentialed behavioral health provider who provides substance use disorder  
25 services in accordance with KRS 304.17A-700 to 304.17A-730.

26 (e) The Department of Insurance may impose a civil penalty of one hundred  
27 dollars (\$100) per violation when a Medicaid managed care organization fails

1 to comply with this section. Each day that a Medicaid managed care  
2 organization fails to pay a claim may count as a separate violation.

3 (13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements  
4 of subsection (12) of this section. The Department for Medicaid Services shall  
5 develop a specific form and establish guidelines for assessing the credentials of  
6 dentists applying for participation in the Medical Assistance Program.

7 ➔Section 6. KRS 304.5-160 is amended to read as follows:

8 (1) Except as otherwise provided in Section 1 of this Act, no health insurance  
9 contracts, plans or policies delivered or issued for delivery in the state shall provide  
10 coverage for elective abortions except by an optional rider for which there must be  
11 paid an additional premium. For purposes of this section, an "elective abortion"  
12 means an abortion for any reason other than to preserve the life of the female upon  
13 whom the abortion is performed.

14 (2) This section shall be applicable to all contracts, plans or policies of:

15 (a) All health insurers subject to Subtitle 17 of KRS Chapter 304; and

16 (b) All group and blanket health insurers subject to Subtitle 18 of KRS Chapter  
17 304; and

18 (c) All nonprofit hospital, medical, surgical, dental and health service  
19 corporations subject to Subtitle 32 of KRS Chapter 304; and

20 (d) All health maintenance organizations subject to Subtitle 38 of KRS Chapter  
21 304; and

22 (e) Any provision of medical, hospital, surgical and funeral benefits and of  
23 coverage against accidental death or injury, when such benefits or coverage  
24 are incidental to or part of other insurance described in KRS 304.5-070(1);  
25 and

26 (f) All employers who provide health insurance for employees on a self-insured  
27 basis.

1       ➔Section 7. KRS 304.32-310 is amended to read as follows:

- 2       (1) A converted policy issued pursuant to the conversion privilege provided in KRS  
3       304.32-300 providing hospital or surgical expense insurance shall provide on an  
4       expense incurred basis, the following minimum benefits:
- 5       (a) Hospital room and board benefits of twenty-five dollars (\$25) per day, for a  
6       minimum duration of seventy (70) days for any one period of hospital  
7       confinement as defined in the converted policy.
- 8       (b) Miscellaneous hospital expense benefits for any one (1) period of hospital  
9       confinement in a minimum amount up to twenty (20) times the hospital room  
10      and board daily benefit provided under the converted policy.
- 11      (c) Surgical operation expense benefits according to a relative value schedule, or  
12      a minimum of two hundred fifty dollars (\$250).
- 13      (d) The option to continue any existing benefits on account of pregnancy,  
14      childbirth, or miscarriage.
- 15      (2) The relative values in the surgical schedule shall be consistent with the schedule of  
16      operations generally offered by the insurer under group or individual health  
17      insurance policies. In the event that the insurer and the employer agree upon one  
18      (1) or more additional plans of benefits to be available for converted policies, the  
19      applicant for the converted policy may, at his option, elect such a plan in lieu of a  
20      converted policy providing the benefits of paragraphs (a), (b), and (c) of subsection  
21      (1) of this section. In no event shall the benefits be less than the minimums set forth  
22      in subsection (1) of this section.
- 23      (3) In no event need the insurer provide under the converted policy:
- 24      (a) Benefits on account of abortion or complications thereof, **except as otherwise**  
25      **provided in Section 1 of this Act;**~~[-]~~
- 26      (b) The benefits of paragraphs (a) and (b) of subsection (1) of this section, unless  
27      the group policy from which conversion is made provided hospital expense

1 insurance benefits; ~~or~~ or

2 (c) The benefits of paragraph (c) of subsection (1) of this section, unless the  
3 group policy provided surgical expense insurance benefits. Furthermore, the  
4 converted policy may contain any exclusion, reduction, or limitation contained  
5 in the group policy and any exclusion, reduction, or limitation customarily  
6 used in individual policies issued by the insurer. With respect to any person  
7 who was covered by the group policy, the period specified in the time limit on  
8 certain defenses of the incontestable provision of the converted policy shall  
9 commence with the date the insurance on such person or member became  
10 effective under the group policy.

11 (4) The converted policy may provide that any hospital, surgical, or medical expense  
12 benefits otherwise payable thereunder with respect to any person covered  
13 thereunder may be reduced by the amount of any such benefits payable under the  
14 group policy for the same loss with respect to such person after termination of such  
15 person's coverage thereunder. The insurer shall not be entitled to use deterioration  
16 of health as the basis for refusing to renew a converted policy. The converted policy  
17 may provide for termination of coverage thereunder on any person when he is or  
18 could be covered by Medicare (Title XVIII of the United States Social Security Act  
19 as added by the Social Security Amendments of 1965 or as later amended or  
20 superseded).

21 (5) A converted policy may include a provision whereby the insurer may request  
22 information in advance of any premium due date of such policy of any person  
23 covered thereunder as to whether:

24 (a) He is covered for similar benefits by another hospital, surgical, or medical  
25 expense insurance policy or hospital or medical service subscriber contract or  
26 medical practice or other prepayment plan or by any other plan or program; or

27 (b) Similar benefits are provided for, or available to, such person pursuant to, or

1           in accordance with the requirements of, any statute.  
2           If any such person is so covered or such statutory benefits are provided or available,  
3           and such person fails to furnish the insurer the details of such coverage within  
4           thirty-one (31) days after the date of such request, the benefits payable under the  
5           converted policy may be based on the hospital or surgical or medical expenses  
6           actually incurred after excluding expenses to the extent of the amount of benefits  
7           provided or available therefor from any of the sources referred to in paragraphs (a)  
8           and (b) of this subsection. A converted policy may contain any provisions permitted  
9           herein and may also include any other provisions not expressly prohibited by law;  
10          and any provision required to be permitted herein may be made a part of any such  
11          policy by means of an endorsement or rider.