1 AN ACT relating to health insurance.

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

3 ➔Section 1. KRS 304.17A-254 is amended to read as follows:

4 An insurer that offers a health benefit plan that is not a managed care plan but provides
5 financial incentives for a covered person to access a network of providers shall:

6 (1) Notify the covered person, in writing, of the availability of a printed document, in a
7 manner consistent with KRS 304.14-420 to 304.14-450, containing the following
8 information at the time of enrollment and upon request:

9 (a) A current directory of the in-network providers from which the covered
10 person may access covered services at a financially beneficial rate. The
11 directory shall, at a minimum, provide the name, type of provider,
12 professional office address, telephone number, and specialty designations of
13 the network provider, if any; and

14 (b) In addition to making the information available in a printed document, an
15 insurer may also make the information available in an accessible electronic
16 format;

17 (2) Assure that contracts with the providers in the network contain a hold harmless
18 agreement under which the covered person will not be balanced billed by the in-
19 network provider except for deductibles, co-pays, coinsurance amounts, and
20 noncovered benefits;

21 (3) File with the department a copy of the directory required under subsection (1) of
22 this section;

23 (4) Have a process for the selection of health care providers who will be on the insurer's
24 list of participating providers, with written policies and procedures for review and
25 approval used by the insurer. The insurer shall establish minimum professional
26 requirements for participating health care providers. An insurer may not
27 discriminate against a provider solely on the basis of the provider's license by the

1 state;
2 (5) Not contract with a health care provider to limit the provider's disclosure to a
3 covered person, or to another person on behalf of a covered person, of any
4 information relating to the covered person's medical condition or treatment options;
5 (6) Not penalize a health care provider, or terminate a health care provider's contract
6 with the insurer, because the provider discusses medically necessary or appropriate
7 care with a covered person or another person on behalf of a covered person. The
8 health care provider may:
9 (a) Not be prohibited by the insurer from discussing all treatment options with the
10 covered person; and
11 (b) Disclose to the covered person or to another person on behalf of a covered
12 person other information determined by the health care provider to be in the
13 best interests of the covered person;
14 (7) Include in any agreements it enters into with providers for the provision of health
15 care services a clause stating that the insurer will, upon request of a health care
16 provider, provide or make available to a health care provider, when contracting or
17 renewing an existing contract with such provider, the payment or fee schedules or
18 other information sufficient to enable the health care provider to determine the
19 manner and amount of payments under the contract for the health care provider's
20 services prior to the final execution or renewal of the contract and shall provide any
21 change in such schedules at least ninety (90) days prior to the effective date of the
22 amendment pursuant to KRS 304.17A-577;
23 (8) Establish a policy governing the removal of and withdrawal by health care providers
24 from the provider network that includes the following:
25 (a) The insurer shall inform a participating health care provider of the insurer's
26 removal and withdrawal policy at the time the insurer contracts with the health
27 care provider to participate in the provider network, and when changed

1 thereafter;
2 (b) If a participating health care provider's participation will be terminated or
3 withdrawn prior to the date of the termination of the contract as a result of a
4 professional review action, the insurer and participating health care provider
5 shall comply with the standards in 42 U.S.C. sec. 11112; and
6 (c) If the insurer finds that a health care provider represents an imminent danger
7 to an individual patient or to the public health, safety, or welfare, the medical
8 director shall promptly notify the appropriate professional state licensing
9 board;~~[and]~~
10 (9) Meet all requirements provided under KRS 304.17A-600 to 304.17A-633 and KRS
11 304.17A-700 to 304.17A-730***; and***
12 ***(10) Not reduce the payment of a negotiated rate for evaluation and management***
13 ***services under a participating provider agreement that are furnished by a***
14 ***participating provider and that are otherwise covered services solely because the***
15 ***provider also billed other health care services, including but not limited to minor***
16 ***surgery, on the same day as the evaluation and management services. Any***
17 ***provision of a provider agreement that allows for a reduction in reimbursement***
18 ***as prohibited by this subsection shall be void***.
19 ➔Section 2. KRS 304.17A-527 is amended to read as follows:
20 (1) A managed care plan shall file with the commissioner sample copies of any
21 agreements it enters into with providers for the provision of health care services.
22 The commissioner shall promulgate administrative regulations prescribing the
23 manner and form of the filings required. The agreements shall include the
24 following:
25 (a) A hold harmless clause that states that the provider may not, under any
26 circumstance, including:
27 1. Nonpayment of moneys due the providers by the managed care plan,

1 2. Insolvency of the managed care plan, or
2 3. Breach of the agreement,
3 bill, charge, collect a deposit, seek compensation, remuneration, or
4 reimbursement from, or have any recourse against the subscriber, dependent
5 of subscriber, enrollee, or any persons acting on their behalf, for services
6 provided in accordance with the provider agreement. This provision shall not
7 prohibit collection of deductible amounts, copayment amounts, coinsurance
8 amounts, and amounts for noncovered services;
9 (b) A continuity of care clause that states that if an agreement between the
10 provider and the managed care plan is terminated for any reason, other than a
11 quality of care issue or fraud, the insurer shall continue to provide services
12 and the plan shall continue to reimburse the provider in accordance with the
13 agreement until the subscriber, dependent of the subscriber, or the enrollee is
14 discharged from an inpatient facility, or the active course of treatment is
15 completed, whichever time is greater, and in the case of a pregnant woman,
16 services shall continue to be provided through the end of the post-partum
17 period if the pregnant woman is in her fourth or later month of pregnancy at
18 the time the agreement is terminated;
19 (c) A survivorship clause that states the hold harmless clause and continuity of
20 care clause shall survive the termination of the agreement between the
21 provider and the managed care plan;
22 (d) A clause stating that the insurer issuing a managed care plan will, upon
23 request of a participating provider, provide or make available to a
24 participating provider, when contracting or renewing an existing contract with
25 such provider, the payment or fee schedules or other information sufficient to
26 enable the provider to determine the manner and amount of payments under
27 the contract for the provider's services prior to the final execution or renewal

1 of the contract and shall provide any change in such schedules at least ninety
2 (90) days prior to the effective date of the amendment pursuant to KRS
3 304.17A-577; and
4 (e) A clause requiring that if a provider enters into any subcontract agreement
5 with another provider to provide their licensed health care services to the
6 subscriber, dependent of the subscriber, or enrollee of a managed care plan
7 where the subcontracted provider will bill the managed care plan or subscriber
8 or enrollee directly for the subcontracted services, the subcontract agreement
9 must meet all requirements of this subtitle and that all such subcontract
10 agreements shall be filed with the commissioner in accordance with this
11 subsection.
12 (2) An insurer that offers a health benefit plan that enters into any risk-sharing
13 arrangement or subcontract agreement shall file a copy of the arrangement with the
14 commissioner. The insurer shall also file the following information regarding the
15 risk-sharing arrangement:
16 (a) The number of enrollees affected by the risk-sharing arrangement;
17 (b) The health care services to be provided to an enrollee under the risk-sharing
18 arrangement;
19 (c) The nature of the financial risk to be shared between the insurer and entity or
20 provider, including but not limited to the method of compensation;
21 (d) Any administrative functions delegated by the insurer to the entity or provider.
22 The insurer shall describe a plan to ensure that the entity or provider will
23 comply with KRS 304.17A-500 to 304.17A-590 in exercising any delegated
24 administrative functions; and
25 (e) The insurer's oversight and compliance plan regarding the standards and
26 method of review.
27 (3) Nothing in this section shall be construed as requiring an insurer to submit the

1 actual financial information agreed to between the insurer and the entity or provider.
2 The commissioner shall have access to a specific risk sharing arrangement with an
3 entity or provider upon request to the insurer. Financial information obtained by the
4 department shall be considered to be a trade secret and shall not be subject to KRS
5 61.872 to 61.884.
6 ***(4) A managed care plan shall not reduce the payment of a negotiated rate for***
7 ***evaluation and management services under a participating provider agreement***
8 ***that are furnished by a participating provider and that are otherwise covered***
9 ***services solely because the provider also billed other health care services,***
10 ***including but not limited to minor surgery, on the same day as the evaluation and***
11 ***management services. Any provision of a provider agreement that allows for a***
12 ***reduction in reimbursement as prohibited by this subsection shall be void.***
13 ➔Section 3. KRS 304.17A-580 is amended to read as follows:
14 (1) An insurer offering health benefit plans shall educate its insureds about the
15 availability, location, and appropriate use of emergency and other medical services,
16 cost-sharing provisions for emergency services, and the availability of care outside
17 an emergency department.
18 (2) ***(a)*** An insurer offering health benefit plans shall cover emergency medical
19 conditions and shall pay for emergency department screening and stabilization
20 services both in-network and out-of-network without prior authorization for
21 conditions that reasonably appear to a prudent layperson to constitute an
22 emergency medical condition based on the patient's presenting symptoms and
23 condition.
24 ***(b)*** An insurer shall be prohibited from denying the emergency room services and
25 altering the level of coverage or cost-sharing requirements ***pursuant to a***
26 ***concurrent or retrospective review, as defined in KRS 304.17A-600,*** for any
27 condition or conditions that ***reasonably appear to a prudent layperson to***

1 constitute an emergency medical condition as defined in KRS 304.17A-500.
2 ***Under no circumstances may an insurer base a final determination of a***
3 ***concurrent or retrospective review on the final diagnosis of the insured.***
4 (3) Emergency department personnel shall contact a patient's primary care provider or
5 insurer, as appropriate, as quickly as possible to discuss follow-up and
6 poststabilization care and promote continuity of care.
7 (4) Nothing in this section shall apply to accident-only, specified disease, hospital
8 indemnity, Medicare supplement, long-term care, disability income, or other
9 limited-benefit health insurance policies.
10 ***(5) Where a covered person with an emergency medical condition has been***
11 ***stabilized, as required by the Consolidated Omnibus Budget Reconciliation Act of***
12 ***1985 (COBRA), 42 U.S.C. sec. 300bb, in the emergency department of a***
13 ***nonparticipating hospital, and an insurer under its health benefit plan requires***
14 ***prior authorization for poststabilization treatment, approval or denial under the***
15 ***preauthorization requirement shall be provided in a timely manner appropriate to***
16 ***conditions of the patient and delivery of the services, but in no case to exceed two***
17 ***(2) hours from the time the request is made and all relevant information is***
18 ***provided. The insurer's failure to make a determination within the two (2) hour***
19 ***time frame, shall constitute an authorization for the hospital to provide the***
20 ***medical service for which prior authorization was sought.***
21 ***(6) The nonparticipating hospital providing emergency room services,***
22 ***poststabilization treatment, or both, shall be paid at a rate negotiated between the***
23 ***nonparticipating hospital and the insurer. Nothing in this section is to be***
24 ***construed as requiring the payment of one hundred percent (100%) of the billed***
25 ***charges.***
26 ➔Section 4. KRS 18A.225 is amended to read as follows:
27 (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, 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;
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, 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

1 insurance program;
2 (b) The term "health benefit plan" for the purposes of this section means a health
3 benefit plan as defined in KRS 304.17A-005;
4 (c) The term "insurer" for the purposes of this section means an insurer as defined
5 in KRS 304.17A-005; and
6 (d) The term "managed care plan" for the purposes of this section means a
7 managed care plan as defined in KRS 304.17A-500.
8 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
9 recommendation of the secretary of the Personnel Cabinet, shall procure, in
10 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
11 from one (1) or more insurers authorized to do business in this state, a group
12 health benefit plan that may include but not be limited to health maintenance
13 organization (HMO), preferred provider organization (PPO), point of service
14 (POS), and exclusive provider organization (EPO) benefit plans encompassing
15 all or any class or classes of employees. With the exception of employers
16 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
17 employers of any class of employees or former employees shall enter into a
18 contract with the Personnel Cabinet prior to including that group in the state
19 health insurance group. The contracts shall include but not be limited to
20 designating the entity responsible for filing any federal forms, adoption of
21 policies required for proper plan administration, acceptance of the contractual
22 provisions with health insurance carriers or third-party administrators, and
23 adoption of the payment and reimbursement methods necessary for efficient
24 administration of the health insurance program. Health insurance coverage
25 provided to state employees under this section shall, at a minimum, contain
26 the same benefits as provided under Kentucky Kare Standard as of January 1,
27 1994, and shall include a mail-order drug option as provided in subsection

1 (13) of this section. All employees and other persons for whom the health care
2 coverage is provided or made available shall annually be given an option to
3 elect health care coverage through a self-funded plan offered by the
4 Commonwealth or, if a self-funded plan is not available, from a list of
5 coverage options determined by the competitive bid process under the
6 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
7 during annual open enrollment.
8 (b) The policy or policies shall be approved by the commissioner of insurance and
9 may contain the provisions the commissioner of insurance approves, whether
10 or not otherwise permitted by the insurance laws.
11 (c) Any carrier bidding to offer health care coverage to employees shall agree to
12 provide coverage to all members of the state group, including active
13 employees and retirees and their eligible covered dependents and
14 beneficiaries, within the county or counties specified in its bid. Except as
15 provided in subsection (20) of this section, any carrier bidding to offer health
16 care coverage to employees shall also agree to rate all employees as a single
17 entity, except for those retirees whose former employers insure their active
18 employees outside the state-sponsored health insurance program.
19 (d) Any carrier bidding to offer health care coverage to employees shall agree to
20 provide enrollment, claims, and utilization data to the Commonwealth in a
21 format specified by the Personnel Cabinet with the understanding that the data
22 shall be owned by the Commonwealth; to provide data in an electronic form
23 and within a time frame specified by the Personnel Cabinet; and to be subject
24 to penalties for noncompliance with data reporting requirements as specified
25 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
26 to protect the confidentiality of each individual employee; however,
27 confidentiality assertions shall not relieve a carrier from the requirement of

1 providing stipulated data to the Commonwealth.
2 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
3 for timely analysis of data received from carriers and, to the extent possible,
4 provide in the request-for-proposal specifics relating to data requirements,
5 electronic reporting, and penalties for noncompliance. The Commonwealth
6 shall own the enrollment, claims, and utilization data provided by each carrier
7 and shall develop methods to protect the confidentiality of the individual. The
8 Personnel Cabinet shall include in the October annual report submitted
9 pursuant to the provisions of KRS 18A.226 to the Governor, the General
10 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
11 financial stability of the program, which shall include but not be limited to
12 loss ratios, methods of risk adjustment, measurements of carrier quality of
13 service, prescription coverage and cost management, and statutorily required
14 mandates. If state self-insurance was available as a carrier option, the report
15 also shall provide a detailed financial analysis of the self-insurance fund
16 including but not limited to loss ratios, reserves, and reinsurance agreements.
17 (f) If any agency participating in the state-sponsored employee health insurance
18 program for its active employees terminates participation and there is a state
19 appropriation for the employer's contribution for active employees' health
20 insurance coverage, then neither the agency nor the employees shall receive
21 the state-funded contribution after termination from the state-sponsored
22 employee health insurance program.
23 (g) Any funds in flexible spending accounts that remain after all reimbursements
24 have been processed shall be transferred to the credit of the state-sponsored
25 health insurance plan's appropriation account.
26 (h) Each entity participating in the state-sponsored health insurance program shall
27 provide an amount at least equal to the state contribution rate for the employer

1 portion of the health insurance premium. For any participating entity that used
2 the state payroll system, the employer contribution amount shall be equal to
3 but not greater than the state contribution rate.
4 (3) The premiums may be paid by the policyholder:
5 (a) Wholly from funds contributed by the employee, by payroll deduction or
6 otherwise;
7 (b) Wholly from funds contributed by any department, board, agency, public
8 postsecondary education institution, or branch of state, city, urban-county,
9 charter county, county, or consolidated local government; or
10 (c) Partly from each, except that any premium due for health care coverage or
11 dental coverage, if any, in excess of the premium amount contributed by any
12 department, board, agency, postsecondary education institution, or branch of
13 state, city, urban-county, charter county, county, or consolidated local
14 government for any other health care coverage shall be paid by the employee.
15 (4) If an employee moves his place of residence or employment out of the service area
16 of an insurer offering a managed health care plan, under which he has elected
17 coverage, into either the service area of another managed health care plan or into an
18 area of the Commonwealth not within a managed health care plan service area, the
19 employee shall be given an option, at the time of the move or transfer, to change his
20 or her coverage to another health benefit plan.
21 (5) No payment of premium by any department, board, agency, public postsecondary
22 educational institution, or branch of state, city, urban-county, charter county,
23 county, or consolidated local government shall constitute compensation to an
24 insured employee for the purposes of any statute fixing or limiting the
25 compensation of such an employee. Any premium or other expense incurred by any
26 department, board, agency, public postsecondary educational institution, or branch
27 of state, city, urban-county, charter county, county, or consolidated local

1 government shall be considered a proper cost of administration.
2 (6) The policy or policies may contain the provisions with respect to the class or classes
3 of employees covered, amounts of insurance or coverage for designated classes or
4 groups of employees, policy options, terms of eligibility, and continuation of
5 insurance or coverage after retirement.
6 (7) Group rates under this section shall be made available to the disabled child of an
7 employee regardless of the child's age if the entire premium for the disabled child's
8 coverage is paid by the state employee. A child shall be considered disabled if he
9 has been determined to be eligible for federal Social Security disability benefits.
10 (8) The health care contract or contracts for employees shall be entered into for a period
11 of not less than one (1) year.
12 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
13 State Health Insurance Subscribers to advise the secretary or his designee regarding
14 the state-sponsored health insurance program for employees. The secretary shall
15 appoint, from a list of names submitted by appointing authorities, members
16 representing school districts from each of the seven (7) Supreme Court districts,
17 members representing state government from each of the seven (7) Supreme Court
18 districts, two (2) members representing retirees under age sixty-five (65), one (1)
19 member representing local health departments, two (2) members representing the
20 Kentucky Teachers' Retirement System, and three (3) members at large. The
21 secretary shall also appoint two (2) members from a list of five (5) names submitted
22 by the Kentucky Education Association, two (2) members from a list of five (5)
23 names submitted by the largest state employee organization of nonschool state
24 employees, two (2) members from a list of five (5) names submitted by the
25 Kentucky Association of Counties, two (2) members from a list of five (5) names
26 submitted by the Kentucky League of Cities, and two (2) members from a list of
27 names consisting of five (5) names submitted by each state employee organization

1 that has two thousand (2,000) or more members on state payroll deduction. The
2 advisory committee shall be appointed in January of each year and shall meet
3 quarterly.
4 (10) Notwithstanding any other provision of law to the contrary, the policy or policies
5 provided to employees pursuant to this section shall not provide coverage for
6 obtaining or performing an abortion, nor shall any state funds be used for the
7 purpose of obtaining or performing an abortion on behalf of employees or their
8 dependents.
9 (11) Interruption of an established treatment regime with maintenance drugs shall be
10 grounds for an insured to appeal a formulary change through the established appeal
11 procedures approved by the Department of Insurance, if the physician supervising
12 the treatment certifies that the change is not in the best interests of the patient.
13 (12) Any employee who is eligible for and elects to participate in the state health
14 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any
15 one (1) of the state-sponsored retirement systems shall not be eligible to receive the
16 state health insurance contribution toward health care coverage as a result of any
17 other employment for which there is a public employer contribution. This does not
18 preclude a retiree and an active employee spouse from using both contributions to
19 the extent needed for purchase of one (1) state sponsored health insurance policy for
20 that plan year.
21 (13) (a) The policies of health insurance coverage procured under subsection (2) of
22 this section shall include a mail-order drug option for maintenance drugs for
23 state employees. Maintenance drugs may be dispensed by mail order in
24 accordance with Kentucky law.
25 (b) A health insurer shall not discriminate against any retail pharmacy located
26 within the geographic coverage area of the health benefit plan and that meets
27 the terms and conditions for participation established by the insurer, including

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

1 services, and the state contribution for the plan shall be the amount available in the
2 county where the plan selected is located.
3 (19) The Personnel Cabinet is encouraged to study whether it is fair and reasonable and
4 in the best interests of the state group to allow any carrier bidding to offer health
5 care coverage under this section to submit bids that may vary county by county or
6 by larger geographic areas.
7 (20) Notwithstanding any other provision of this section, the bid for proposals for health
8 insurance coverage for calendar year 2004 shall include a bid scenario that reflects
9 the statewide rating structure provided in calendar year 2003 and a bid scenario that
10 allows for a regional rating structure that allows carriers to submit bids that may
11 vary by region for a given product offering as described in this subsection:
12 (a) The regional rating bid scenario shall not include a request for bid on a
13 statewide option;
14 (b) The Personnel Cabinet shall divide the state into geographical regions which
15 shall be the same as the partnership regions designated by the Department for
16 Medicaid Services for purposes of the Kentucky Health Care Partnership
17 Program established pursuant to 907 KAR 1:705;
18 (c) The request for proposal shall require a carrier's bid to include every county
19 within the region or regions for which the bid is submitted and include but not
20 be restricted to a preferred provider organization (PPO) option;
21 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
22 carrier all of the counties included in its bid within the region. If the Personnel
23 Cabinet deems the bids submitted in accordance with this subsection to be in
24 the best interests of state employees in a region, the cabinet may award the
25 contract for that region to no more than two (2) carriers; and
26 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
27 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 July 12, 2006, to public employees pursuant to this section shall comply with the provisions of KRS 304.17A-270 and 304.17A-525.

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

➔Section 5. The following KRS sections are repealed:

304.17A-640 Definitions for KRS 304.17A-640 et seq.

304.17A-641 Treatment of a stabilized covered person with an emergency medical condition in a nonparticipating hospital's emergency room.

304.17A-649 Administrative regulations for the implementation of KRS 304.17A-640 et seq.