

1 AN ACT relating to telehealth.

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

3 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
4 READ AS FOLLOWS:

5 *(1) The cabinet shall provide oversight, guidance, and direction to Medicaid*
6 *providers delivering care using telehealth as defined in Section 2 of this Act.*

7 *(2) The cabinet shall:*

8 *(a) Develop policies and procedures to ensure the proper use and security for*
9 *telehealth, including but not limited to confidentiality and data integrity,*
10 *privacy and security, informed consent, privileging and credentialing,*
11 *reimbursement, and technology;*

12 *(b) Promote access to health care provided via telehealth; and*

13 *(c) Maintain a list of Medicaid providers who may deliver telehealth services to*
14 *Medicaid recipients throughout the Commonwealth.*

15 *(3) The cabinet or any health benefit plan shall not:*

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

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

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

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

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

- 1 (f) Require a Medicaid provider to be part of a telehealth network.
- 2 (4) The Medicaid program or any health benefit plan shall reimburse for covered
 3 services provided to a Medicaid recipient through telehealth, as defined in
 4 Section 2 of this Act. Telehealth coverage and reimbursement shall be equivalent
 5 to the coverage and reimbursement for the same service provided in person.
- 6 (5) Benefits for a service provided to a Medicaid recipient through telehealth may be
 7 made subject to a deductible, copayment, or coinsurance requirement. A
 8 deductible, copayment, or coinsurance applicable to a particular service provided
 9 through telehealth shall not exceed the deductible, copayment, or coinsurance
 10 required by the Medicaid program for the same service provided in person.
- 11 (6) Nothing in this section shall be construed to require the Medicaid program or
 12 any health benefit plan to:
- 13 (a) Provide coverage for telehealth services that are not medically necessary; or
 14 (b) Reimburse any fees charged by a telehealth facility for transmission of a
 15 telehealth encounter.
- 16 (7) The cabinet shall maintain telehealth policies and guidelines to providing care
 17 that ensure that Medicaid-eligible citizens will have safe, adequate, and efficient
 18 medical care, and that prevent waste, fraud, and abuse of the Medicaid program.

19 ➔Section 2. KRS 205.510 is amended to read as follows:

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

- 22 (1) "Chiropractor" means a person authorized to practice chiropractic under KRS
 23 Chapter 312;
- 24 (2) "Council" means the Advisory Council for Medical Assistance;
- 25 (3) "Dentist" means a person authorized to practice dentistry under laws of the
 26 Commonwealth;
- 27 (4) "Health professional" means a physician, physician assistant, nurse, doctor of

- 1 chiropractic, mental health professional, optometrist, dentist, or allied health
2 professional who is licensed in Kentucky;
- 3 (5) "Medical care" as used in this chapter means essential medical, surgical,
4 chiropractic, dental, optometric, podiatric, telehealth, and nursing services, in the
5 home, office, clinic, or other suitable places, which are provided or prescribed by
6 physicians, optometrists, podiatrists, or dentists licensed to render such services,
7 including drugs and medical supplies, appliances, laboratory, diagnostic and
8 therapeutic services, nursing-home and convalescent care, hospital care as defined
9 in KRS 205.560(1)(a), and such other essential medical services and supplies as
10 may be prescribed by such persons; but not including abortions, or induced
11 miscarriages or premature births, unless in the opinion of a physician such
12 procedures are necessary for the preservation of the life of the woman seeking such
13 treatment or except in induced premature birth intended to produce a live viable
14 child and such procedure is necessary for the health of the mother or her unborn
15 child. However, this section does not authorize optometrists to perform any services
16 other than those authorized by KRS Chapter 320;
- 17 (6) "Nurse" means a person authorized to practice professional nursing under the laws
18 of the Commonwealth;
- 19 (7) "Nursing home" means a facility which provides routine medical care in which
20 physicians regularly visit patients, which provide nursing services and procedures
21 employed in caring for the sick which require training, judgment, technical
22 knowledge, and skills beyond that which the untrained person possesses, and which
23 maintains complete records on patient care, and which is licensed pursuant to the
24 provisions of KRS 216B.015;
- 25 (8) "Optometrist" means a person authorized to practice optometry under the laws of
26 the Commonwealth;
- 27 (9) "Other persons eligible for medical assistance" may include the categorically needy

1 excluded from money payment status by state requirements and classifications of
2 medically needy individuals as permitted by federal laws and regulations and as
3 prescribed by administrative regulation of the secretary for health and family
4 services or his designee;

5 (10) "Pharmacist" means a person authorized to practice pharmacy under the laws of the
6 Commonwealth;

7 (11) "Physician" means a person authorized to practice medicine or osteopathy under the
8 laws of the Commonwealth;

9 (12) "Podiatrist" means a person authorized to practice podiatry under the laws of the
10 Commonwealth;

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

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

18 (15) **"Telehealth":**

19 **(a) Means the reimbursable delivery of health care-related services by a**
20 **Medicaid provider who is a health care provider licensed in Kentucky to a**
21 **Medicaid recipient through a face-to-face encounter using real-time**
22 **interactive audio and video technology;**

23 **(b) May include store and forward services that are provided via asynchronous**
24 **technologies as the standard practice of care, including but not limited to**
25 **radiology and ultrasound studies, diabetic retinal exams, pathology, and**
26 **similar services where images are sent to a specialist for evaluation;**

27 **(c) Shall not include the delivery of services through electronic mail, text chat,**

1 *facsimile, or standard audio-only telephone call; and*
 2 *(d) Shall be delivered over a secure communications connection that complies*
 3 *with the federal Health Insurance Portability and Accountability Act of*
 4 *1996, 42 U.S.C. secs. 1320d to 1320d-9;*

5 **(16)** "Telehealth consultation" means a medical or health consultation, for purposes of
 6 patient diagnosis or treatment, that *meets the definition of telehealth in this*
 7 *section*~~requires the use of advanced telecommunications technology, including, but~~
 8 ~~not limited to:~~

9 ~~(a) Compressed digital interactive video, audio, or data transmission;~~
 10 ~~(b) Clinical data transmission via computer imaging for teleradiology or~~
 11 ~~telepathology; and~~
 12 ~~(c) Other technology that facilitates access to health care services or medical~~
 13 ~~specialty expertise];~~

14 **(17)**~~**(16)**~~ "Third party" means an individual, institution, corporation, company,
 15 insurance company, personal representative, administrator, executor, trustee, or
 16 public or private agency, including, but not limited to, a reparation obligor and the
 17 assigned claims bureau under the Motor Vehicle Reparations Act, Subtitle 39 of
 18 KRS Chapter 304, who is or may be liable to pay all or part of the medical cost of
 19 injury, disease, or disability of an applicant or recipient of medical assistance
 20 provided under Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 et seq.;

21 and

22 **(18)**~~**(17)**~~ "Vendor payment" means a payment for medical care which is paid by the
 23 Cabinet for Health and Family Services directly to the authorized person or
 24 institution which rendered medical care to an eligible recipient.

25 ➔Section 3. KRS 205.559 is amended to read as follows:

26 (1) The Cabinet for Health and Family Services and any regional managed care
 27 partnership or other entity under contract with the cabinet for the administration or

1 provision of the Medicaid program shall provide Medicaid reimbursement for a
2 telehealth consultation as defined in Section 2 of this Act that is provided by a
3 Medicaid-participating practitioner who is licensed in Kentucky ~~and that is~~
4 ~~provided in the telehealth network established in KRS 194A.125(3)(b)]~~.

5 (2) (a) The cabinet shall establish reimbursement rates for telehealth consultations. A
6 request for reimbursement shall not be denied solely because an in-person
7 consultation between a Medicaid-participating practitioner and a patient did
8 not occur.

9 (b) A telehealth consultation shall not be reimbursable under this section if it is
10 provided through the use of an audio-only telephone, facsimile machine, or
11 electronic mail.

12 (3) A health-care facility that receives reimbursement under this section for
13 consultations provided by a Medicaid-participating provider who practices in that
14 facility and a health professional who obtains a consultation under this section shall
15 establish quality-of-care protocols and patient confidentiality guidelines to ensure
16 that telehealth consultations meet all requirements and patient care standards as
17 required by law.

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

21 (5) The cabinet shall request any waivers of federal laws or regulations that may be
22 necessary to implement this section.

23 (6) (a) The cabinet and any regional managed care partnership or other entity under
24 contract with the cabinet for the administration or provision of the Medicaid
25 program shall study the impact of this section on the health care delivery
26 system in Kentucky and shall, upon implementation, issue a quarterly report to
27 the Legislative Research Commission. This report shall include an analysis of:

- 1 1. The economic impact of this section on the Medicaid budget, including
2 any costs or savings as a result of decreased transportation expenditures
3 and office or emergency room visits;
- 4 2. The quality of care as a result of telehealth consultations rendered under
5 this section; and
- 6 3. Any other issues deemed relevant by the cabinet.
- 7 (b) In addition to the analysis required under paragraph (a) of this subsection, the
8 cabinet report shall compare telehealth reimbursement and delivery among all
9 regional managed care partnerships or other entities under contract with the
10 cabinet for the administration or provision of the Medicaid program.
- 11 (7) The cabinet shall promulgate an administrative regulation in accordance with KRS
12 Chapter 13A to designate the claim forms, records required, and authorization
13 procedures to be followed in conjunction with this section.
- 14 ➔Section 4. KRS 304.17A-005 is amended to read as follows:
- 15 As used in this subtitle, unless the context requires otherwise:
- 16 (1) "Association" means an entity, other than an employer-organized association, that
17 has been organized and is maintained in good faith for purposes other than that of
18 obtaining insurance for its members and that has a constitution and bylaws;
- 19 (2) "At the time of enrollment" means:
- 20 (a) At the time of application for an individual, an association that actively
21 markets to individual members, and an employer-organized association that
22 actively markets to individual members; and
- 23 (b) During the time of open enrollment or during an insured's initial or special
24 enrollment periods for group health insurance;
- 25 (3) "Base premium rate" means, for each class of business as to a rating period, the
26 lowest premium rate charged or that could have been charged under the rating
27 system for that class of business by the insurer to the individual or small group, or

- 1 employer as defined in KRS 304.17A-0954, with similar case characteristics for
2 health benefit plans with the same or similar coverage;
- 3 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,
4 or employer-organized association that limits coverage to physician, pharmacy,
5 home health, preventive, emergency, and inpatient and outpatient hospital services
6 in accordance with the requirements of this subtitle. If vision or eye services are
7 offered, these services may be provided by an ophthalmologist or optometrist.
8 Chiropractic benefits may be offered by providers licensed pursuant to KRS
9 Chapter 312;
- 10 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
11 91(d)(3);
- 12 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
- 13 (7) "COBRA" means any of the following:
- 14 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
15 vaccines;
- 16 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
17 et seq. other than sec. 1169); or
- 18 (c) 42 U.S.C. sec. 300bb;
- 19 (8) (a) "Creditable coverage" means, with respect to an individual, coverage of the
20 individual under any of the following:
- 21 1. A group health plan;
- 22 2. Health insurance coverage;
- 23 3. Part A or Part B of Title XVIII of the Social Security Act;
- 24 4. Title XIX of the Social Security Act, other than coverage consisting
25 solely of benefits under section 1928;
- 26 5. Chapter 55 of Title 10, United States Code, including medical and dental
27 care for members and certain former members of the uniformed services,

- 1 and for their dependents; for purposes of Chapter 55 of Title 10, United
2 States Code, "uniformed services" means the Armed Forces and the
3 Commissioned Corps of the National Oceanic and Atmospheric
4 Administration and of the Public Health Service;
- 5 6. A medical care program of the Indian Health Service or of a tribal
6 organization;
- 7 7. A state health benefits risk pool;
- 8 8. A health plan offered under Chapter 89 of Title 5, United States Code,
9 such as the Federal Employees Health Benefit Program;
- 10 9. A public health plan as established or maintained by a state, the United
11 States government, a foreign country, or any political subdivision of a
12 state, the United States government, or a foreign country that provides
13 health coverage to individuals who are enrolled in the plan;
- 14 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
15 U.S.C. sec. 2504(e)); or
- 16 11. Title XXI of the Social Security Act, such as the State Children's Health
17 Insurance Program.
- 18 (b) This term does not include coverage consisting solely of coverage of excepted
19 benefits as defined in subsection (14) of this section;
- 20 (9) "Dependent" means any individual who is or may become eligible for coverage
21 under the terms of an individual or group health benefit plan because of a
22 relationship to a participant;
- 23 (10) "Employee benefit plan" means an employee welfare benefit plan or an employee
24 pension benefit plan or a plan which is both an employee welfare benefit plan and
25 an employee pension benefit plan as defined by ERISA;
- 26 (11) "Eligible individual" means an individual:
- 27 (a) For whom, as of the date on which the individual seeks coverage, the

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

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

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

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

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

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

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

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

27 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-

1 91(d)(3), whose members consist principally of employers, and for which the
2 entity's health insurance decisions are made by a board or committee, the
3 majority of which are representatives of employer members of the entity who
4 obtain group health insurance coverage through the entity or through a trust or
5 other mechanism established by the entity, and whose health insurance
6 decisions are reflected in written minutes or other written documentation.

7 Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and
8 except as otherwise provided by the definition of "large group" contained in
9 subsection (30) of this section, an employer-organized association shall not be
10 treated as an association, small group, or large group under this subtitle, provided
11 that an employer-organized association that is a bona fide association as defined in
12 subsection (5) of this section shall be treated as a large group under this subtitle;

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

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

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

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

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

26 (d) Workers' compensation or similar insurance;

27 (e) Automobile medical payment insurance;

- 1 (f) Credit-only insurance;
- 2 (g) Coverage for on-site medical clinics;
- 3 (h) Other similar insurance coverage, specified in administrative regulations,
4 under which benefits for medical care are secondary or incidental to other
5 insurance benefits;
- 6 (i) Limited scope dental or vision benefits;
- 7 (j) Benefits for long-term care, nursing home care, home health care, community-
8 based care, or any combination thereof;
- 9 (k) Such other similar, limited benefits as are specified in administrative
10 regulations;
- 11 (l) Coverage only for a specified disease or illness;
- 12 (m) Hospital indemnity or other fixed indemnity insurance;
- 13 (n) Benefits offered as Medicare supplemental health insurance, as defined under
14 section 1882(g)(1) of the Social Security Act;
- 15 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
16 United States Code;
- 17 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
18 supplemental to coverage under a group health plan; and
- 19 (q) Health flexible spending arrangements;
- 20 (15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
21 1002(32);
- 22 (16) "Group health plan" means a plan, including a self-insured plan, of or contributed to
23 by an employer, including a self-employed person, or employee organization, to
24 provide health care directly or otherwise to the employees, former employees, the
25 employer, or others associated or formerly associated with the employer in a
26 business relationship, or their families;
- 27 (17) "Guaranteed acceptance program participating insurer" means an insurer that is

- 1 required to or has agreed to offer health benefit plans in the individual market to
2 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
3 304.17A-480;
- 4 (18) "Guaranteed acceptance program plan" means a health benefit plan in the individual
5 market issued by an insurer that provides health benefits to a guaranteed acceptance
6 program qualified individual and is eligible for assessment and refunds under the
7 guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
- 8 (19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance
9 Program established and operated under KRS 304.17A-400 to 304.17A-480;
- 10 (20) "Guaranteed acceptance program qualified individual" means an individual who, on
11 or before December 31, 2000:
- 12 (a) Is not an eligible individual;
- 13 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
14 spouse or a dependent of an individual who:
- 15 1. Waived coverage under KRS 304.17A-210(2); or
16 2. Did not elect family coverage that was available through the association
17 or group market;
- 18 (c) Within the previous three (3) years has been diagnosed with or treated for a
19 high-cost condition or has had benefits paid under a health benefit plan for a
20 high-cost condition, or is a high risk individual as defined by the underwriting
21 criteria applied by an insurer under the alternative underwriting mechanism
22 established in KRS 304.17A-430(3);
- 23 (d) Has been a resident of Kentucky for at least twelve (12) months immediately
24 preceding the effective date of the policy; and
- 25 (e) Has not had his or her most recent coverage under any health benefit plan
26 terminated or nonrenewed because of any of the following:
- 27 1. The individual failed to pay premiums or contributions in accordance

1 with the terms of the plan or the insurer had not received timely
2 premium payments;

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

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

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

13 (22) "Health benefit plan" means any hospital or medical expense policy or certificate;
14 nonprofit hospital, medical-surgical, and health service corporation contract or
15 certificate; provider sponsored integrated health delivery network; a self-insured
16 plan or a plan provided by a multiple employer welfare arrangement, to the extent
17 permitted by ERISA; health maintenance organization contract; or any health
18 benefit plan that affects the rights of a Kentucky insured and bears a reasonable
19 relation to Kentucky, whether delivered or issued for delivery in Kentucky, and
20 does not include policies covering only accident, credit, dental, disability income,
21 fixed indemnity medical expense reimbursement policy, long-term care, Medicare
22 supplement, specified disease, vision care, coverage issued as a supplement to
23 liability insurance, insurance arising out of a workers' compensation or similar law,
24 automobile medical-payment insurance, insurance under which benefits are payable
25 with or without regard to fault and that is statutorily required to be contained in any
26 liability insurance policy or equivalent self-insurance, short-term coverage, student
27 health insurance offered by a Kentucky-licensed insurer under written contract with

1 a university or college whose students it proposes to insure, medical expense
2 reimbursement policies specifically designed to fill gaps in primary coverage,
3 coinsurance, or deductibles and provided under a separate policy, certificate, or
4 contract, or coverage supplemental to the coverage provided under Chapter 55 of
5 Title 10, United States Code, or limited health service benefit plans, or direct
6 primary care agreements established under KRS 311.6201, 311.6202, 314.198, and
7 314.199;

8 (23) "Health care provider" or "provider" means any facility or service required to be
9 licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS
10 Chapter 315, or home medical equipment and services provider as defined pursuant
11 to KRS 309.402, and any of the following independent practicing practitioners:

12 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

13 (b) Chiropractors licensed under KRS Chapter 312;

14 (c) Dentists licensed under KRS Chapter 313;

15 (d) Optometrists licensed under KRS Chapter 320;

16 (e) Physician assistants regulated under KRS Chapter 311;

17 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and

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

20 (24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
21 Program, means a covered condition in an individual policy as listed in
22 paragraph (c) of this subsection or as added by the commissioner in
23 accordance with KRS 304.17A-280, but only to the extent that the condition
24 exceeds the numerical score or rating established pursuant to uniform
25 underwriting standards prescribed by the commissioner under paragraph (b) of
26 this subsection that account for the severity of the condition and the cost
27 associated with treating that condition.

- 1 (b) The commissioner by administrative regulation shall establish uniform
2 underwriting standards and a score or rating above which a condition is
3 considered to be high-cost by using:
- 4 1. Codes in the most recent version of the "International Classification of
5 Diseases" that correspond to the medical conditions in paragraph (c) of
6 this subsection and the costs for administering treatment for the
7 conditions represented by those codes; and
 - 8 2. The most recent version of the questionnaire incorporated in a national
9 underwriting guide generally accepted in the insurance industry as
10 designated by the commissioner, the scoring scale for which shall be
11 established by the commissioner.
- 12 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
13 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
14 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
15 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
16 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
17 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,
18 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
19 stroke, syringomyelia, and Wilson's disease;
- 20 (25) "Index rate" means, for each class of business as to a rating period, the arithmetic
21 average of the applicable base premium rate and the corresponding highest premium
22 rate;
- 23 (26) "Individual market" means the market for the health insurance coverage offered to
24 individuals other than in connection with a group health plan. The individual market
25 includes an association plan that is not employer related, issued to individuals on an
26 individually underwritten basis, other than an employer-organized association or a
27 bona fide association, that has been organized and is maintained in good faith for

1 purposes other than obtaining insurance for its members and that has a constitution
2 and bylaws;

3 (27) "Insurer" means any insurance company; health maintenance organization; self-
4 insurer or multiple employer welfare arrangement not exempt from state regulation
5 by ERISA; provider-sponsored integrated health delivery network; self-insured
6 employer-organized association, or nonprofit hospital, medical-surgical, dental, or
7 health service corporation authorized to transact health insurance business in
8 Kentucky;

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

15 (29) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

16 (30) "Large group" means:

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

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

19 (c) An employer-organized association that is a bona fide association as defined
20 in subsection (5) of this section;

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

- 1 (32) "Market segment" means the portion of the market covering one (1) of the
2 following:
- 3 (a) Individual;
 - 4 (b) Small group;
 - 5 (c) Large group; or
 - 6 (d) Association;
- 7 (33) "Participant" means any employee or former employee of an employer, or any
8 member or former member of an employee organization, who is or may become
9 eligible to receive a benefit of any type from an employee benefit plan which covers
10 employees of the employer or members of the organization, or whose beneficiaries
11 may be eligible to receive any benefit as established in Section 3(7) of ERISA;
- 12 (34) "Preventive services" means medical services for the early detection of disease that
13 are associated with substantial reduction in morbidity and mortality;
- 14 (35) "Provider network" means an affiliated group of varied health care providers that is
15 established to provide a continuum of health care services to individuals;
- 16 (36) "Provider-sponsored integrated health delivery network" means any provider-
17 sponsored integrated health delivery network created and qualified under KRS
18 304.17A-300 and KRS 304.17A-310;
- 19 (37) "Purchaser" means an individual, organization, employer, association, or the
20 Commonwealth that makes health benefit purchasing decisions on behalf of a group
21 of individuals;
- 22 (38) "Rating period" means the calendar period for which premium rates are in effect. A
23 rating period shall not be required to be a calendar year;
- 24 (39) "Restricted provider network" means a health benefit plan that conditions the
25 payment of benefits, in whole or in part, on the use of the providers that have
26 entered into a contractual arrangement with the insurer to provide health care
27 services to covered individuals;

- 1 (40) "Self-insured plan" means a group health insurance plan in which the sponsoring
 2 organization assumes the financial risk of paying for covered services provided to
 3 its enrollees;
- 4 (41) "Small employer" means, in connection with a group health plan with respect to a
 5 calendar year and a plan year, an employer who employed an average of at least two
 6 (2) but not more than fifty (50) employees on business days during the preceding
 7 calendar year and who employs at least two (2) employees on the first day of the
 8 plan year;
- 9 (42) "Small group" means:
- 10 (a) A small employer with two (2) to fifty (50) employees; or
- 11 (b) An affiliated group or association with two (2) to fifty (50) eligible members;
- 12 (43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and
- 13 (44) "Telehealth":
- 14 **(a) Means the reimbursable delivery of health care-related services by a health**
 15 **care provider who is licensed in Kentucky to a patient or client through a**
 16 **face-to-face encounter using real-time interactive audio and video**
 17 **technology;**
- 18 **(b) May include store and forward services that are provided via asynchronous**
 19 **technologies as the standard practice of care, including but not limited to**
 20 **radiology and ultrasound studies, diabetic retinal exams, pathology, and**
 21 **other similar services where images are sent to a specialist for evaluation;**
- 22 **(c) Shall not include the delivery of services through electronic mail, text chat,**
 23 **facsimile, or standard audio-only telephone call; and shall be delivered over**
 24 **a secure communications connection that complies with the federal Health**
 25 **Insurance Portability and Accountability Act of 1996, 42 U.S.C. secs. 1320d**
 26 **to 1320d-9** has the meaning provided in KRS 311.550].
- 27 ➔Section 5. KRS 304.17A-138 is amended to read as follows:

- 1 (1) (a) A health benefit plan shall include coverage for services provided to an
2 insured person through telehealth as defined in Section 4 of this Act.
3 Telehealth coverage and reimbursement shall be equivalent to the coverage
4 and reimbursement for the same service provided in person~~[not exclude a~~
5 ~~service from coverage solely because the service is provided through~~
6 ~~telehealth and not provided through a face to face consultation if the~~
7 ~~consultation is provided through the telehealth network established under~~
8 ~~KRS 194A.125. A health benefit plan may provide coverage for a consultation~~
9 ~~at a site not within the telehealth network at the discretion of the insurer].~~
- 10 (b) A health benefit plan shall not:
- 11 1. Require a provider to be physically present with a patient or client,
12 unless the provider determines that it is necessary to perform those
13 services in person;
 - 14 2. Require prior authorization, medical review, or administrative
15 clearance for telehealth that would not be required if a service were
16 provided in person;
 - 17 3. Require demonstration that it is necessary to provide services to a
18 patient or client through telehealth;
 - 19 4. Require a provider to be employed by another provider or agency in
20 order to provide telehealth services that would not be required if that
21 service were provided in person;
 - 22 5. Restrict or deny coverage of telehealth based solely on the
23 communication technology or application used to deliver the
24 telehealth services; or
 - 25 6. Require a provider to be part of a telehealth network~~[A telehealth~~
26 ~~consultation shall not be reimbursable under this section if it is provided~~
27 ~~through the use of an audio-only telephone, facsimile machine, or~~

1 ~~electronic mail~~].

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

8 (3) **Nothing in this section shall be construed to require a health benefit plan to:**

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

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

12 **(4)** Payment made under this section may be consistent with any provider network
13 arrangements that have been established for the health benefit plan.

14 **(5)**~~[(4)]~~ The department shall promulgate an administrative regulation in accordance
15 with KRS Chapter 13A to designate the claim forms and records required to be
16 maintained in conjunction with this section.

17 ➔Section 6. KRS 342.315 is amended to read as follows:

18 (1) The commissioner shall contract with the University of Kentucky and the
19 University of Louisville medical schools to evaluate workers who have had injuries
20 or become affected by occupational diseases covered by this chapter. Referral for
21 evaluation may be made to one (1) of the medical schools whenever a medical
22 question is at issue.

23 (2) The physicians and institutions performing evaluations pursuant to this section shall
24 render reports encompassing their findings and opinions in the form prescribed by
25 the commissioner. Except as otherwise provided in KRS 342.316, the clinical
26 findings and opinions of the designated evaluator shall be afforded presumptive
27 weight by administrative law judges and the burden to overcome such findings and

1 opinions shall fall on the opponent of that evidence. When administrative law
2 judges reject the clinical findings and opinions of the designated evaluator, they
3 shall specifically state in the order the reasons for rejecting that evidence.

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

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

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

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

1 conducted in accordance with the standards prescribed in this chapter.

2 (7) The General Assembly finds that good public policy mandates the realization of the
3 potential advantages, both economic and effectual, of the use of ~~telemedicine and~~
4 ~~telehealth~~. The commissioner may, to the extent that he or she finds it feasible and
5 appropriate, require the use of ~~telemedicine and~~ telehealth ~~practices,~~ as ***defined***
6 ***in Section 4 of this Act***~~[authorized under KRS 194A.125]~~, in the independent
7 medical evaluation process required by this chapter.

8 ➔Section 7. KRS 18A.225 is amended to read as follows:

- 9 (1) (a) The term "employee" for purposes of this section means:
- 10 1. Any person, including an elected public official, who is regularly
11 employed by any department, office, board, agency, or branch of state
12 government; or by a public postsecondary educational institution; or by
13 any city, urban-county, charter county, county, or consolidated local
14 government, whose legislative body has opted to participate in the state-
15 sponsored health insurance program pursuant to KRS 79.080; and who
16 is either a contributing member to any one (1) of the retirement systems
17 administered by the state, including but not limited to the Kentucky
18 Retirement Systems, Kentucky Teachers' Retirement System, the
19 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is
20 receiving a contractual contribution from the state toward a retirement
21 plan; or, in the case of a public postsecondary education institution, is an
22 individual participating in an optional retirement plan authorized by
23 KRS 161.567;
 - 24 2. Any certified or classified employee of a local board of education;
 - 25 3. Any elected member of a local board of education;
 - 26 4. Any person who is a present or future recipient of a retirement
27 allowance from the Kentucky Retirement Systems, Kentucky Teachers'

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

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

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

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

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

17 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
18 recommendation of the secretary of the Personnel Cabinet, shall procure, in
19 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
20 from one (1) or more insurers authorized to do business in this state, a group
21 health benefit plan that may include but not be limited to health maintenance
22 organization (HMO), preferred provider organization (PPO), point of service
23 (POS), and exclusive provider organization (EPO) benefit plans encompassing
24 all or any class or classes of employees. With the exception of employers
25 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
26 employers of any class of employees or former employees shall enter into a
27 contract with the Personnel Cabinet prior to including that group in the state

1 health insurance group. The contracts shall include but not be limited to
2 designating the entity responsible for filing any federal forms, adoption of
3 policies required for proper plan administration, acceptance of the contractual
4 provisions with health insurance carriers or third-party administrators, and
5 adoption of the payment and reimbursement methods necessary for efficient
6 administration of the health insurance program. Health insurance coverage
7 provided to state employees under this section shall, at a minimum, contain
8 the same benefits as provided under Kentucky Kare Standard as of January 1,
9 1994, and shall include a mail-order drug option as provided in subsection
10 (13) of this section. All employees and other persons for whom the health care
11 coverage is provided or made available shall annually be given an option to
12 elect health care coverage through a self-funded plan offered by the
13 Commonwealth or, if a self-funded plan is not available, from a list of
14 coverage options determined by the competitive bid process under the
15 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
16 during annual open enrollment.

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

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

- 1 (d) Any carrier bidding to offer health care coverage to employees shall agree to
2 provide enrollment, claims, and utilization data to the Commonwealth in a
3 format specified by the Personnel Cabinet with the understanding that the data
4 shall be owned by the Commonwealth; to provide data in an electronic form
5 and within a time frame specified by the Personnel Cabinet; and to be subject
6 to penalties for noncompliance with data reporting requirements as specified
7 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
8 to protect the confidentiality of each individual employee; however,
9 confidentiality assertions shall not relieve a carrier from the requirement of
10 providing stipulated data to the Commonwealth.
- 11 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
12 for timely analysis of data received from carriers and, to the extent possible,
13 provide in the request-for-proposal specifics relating to data requirements,
14 electronic reporting, and penalties for noncompliance. The Commonwealth
15 shall own the enrollment, claims, and utilization data provided by each carrier
16 and shall develop methods to protect the confidentiality of the individual. The
17 Personnel Cabinet shall include in the October annual report submitted
18 pursuant to the provisions of KRS 18A.226 to the Governor, the General
19 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
20 financial stability of the program, which shall include but not be limited to
21 loss ratios, methods of risk adjustment, measurements of carrier quality of
22 service, prescription coverage and cost management, and
23 statutorily~~statutorially~~ required mandates. If state self-insurance was
24 available as a carrier option, the report also shall provide a detailed financial
25 analysis of the self-insurance fund including but not limited to loss ratios,
26 reserves, and reinsurance agreements.
- 27 (f) If any agency participating in the state-sponsored employee health insurance

1 program for its active employees terminates participation and there is a state
2 appropriation for the employer's contribution for active employees' health
3 insurance coverage, then neither the agency nor the employees shall receive
4 the state-funded contribution after termination from the state-sponsored
5 employee health insurance program.

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

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

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

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

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

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

25 (4) If an employee moves his place of residence or employment out of the service area
26 of an insurer offering a managed health care plan, under which he has elected
27 coverage, into either the service area of another managed health care plan or into an

1 area of the Commonwealth not within a managed health care plan service area, the
2 employee shall be given an option, at the time of the move or transfer, to change his
3 or her coverage to another health benefit plan.

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

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

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

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

22 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
23 State Health Insurance Subscribers to advise the secretary or his designee regarding
24 the state-sponsored health insurance program for employees. The secretary shall
25 appoint, from a list of names submitted by appointing authorities, members
26 representing school districts from each of the seven (7) Supreme Court districts,
27 members representing state government from each of the seven (7) Supreme Court

1 districts, two (2) members representing retirees under age sixty-five (65), one (1)
2 member representing local health departments, two (2) members representing the
3 Kentucky Teachers' Retirement System, and three (3) members at large. The
4 secretary shall also appoint two (2) members from a list of five (5) names submitted
5 by the Kentucky Education Association, two (2) members from a list of five (5)
6 names submitted by the largest state employee organization of nonschool state
7 employees, two (2) members from a list of five (5) names submitted by the
8 Kentucky Association of Counties, two (2) members from a list of five (5) names
9 submitted by the Kentucky League of Cities, and two (2) members from a list of
10 names consisting of five (5) names submitted by each state employee organization
11 that has two thousand (2,000) or more members on state payroll deduction. The
12 advisory committee shall be appointed in January of each year and shall meet
13 quarterly.

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

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

23 (12) Any employee who is eligible for and elects to participate in the state health
24 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any
25 one (1) of the state-sponsored retirement systems shall not be eligible to receive the
26 state health insurance contribution toward health care coverage as a result of any
27 other employment for which there is a public employer contribution. This does not

1 preclude a retiree and an active employee spouse from using both contributions to
2 the extent needed for purchase of one (1) state sponsored health insurance policy for
3 that plan year.

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

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

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

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

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

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

26 (17) If a state employee's residence and place of employment are in the same county, and
27 if the hospital located within that county does not offer surgical services, intensive

1 care services, obstetrical services, level II neonatal services, diagnostic cardiac
2 catheterization services, and magnetic resonance imaging services, the employee
3 may select a plan available in a contiguous county that does provide those services,
4 and the state contribution for the plan shall be the amount available in the county
5 where the plan selected is located.

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

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

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

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

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

- 1 (c) The request for proposal shall require a carrier's bid to include every county
2 within the region or regions for which the bid is submitted and include but not
3 be restricted to a preferred provider organization (PPO) option;
- 4 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
5 carrier all of the counties included in its bid within the region. If the Personnel
6 Cabinet deems the bids submitted in accordance with this subsection to be in
7 the best interests of state employees in a region, the cabinet may award the
8 contract for that region to no more than two (2) carriers; and
- 9 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
10 other requirements or criteria in the request for proposal.
- 11 (21) Any fully insured health benefit plan or self-insured plan issued or renewed on or
12 after July 12, 2006, to public employees pursuant to this section which provides
13 coverage for services rendered by a physician or osteopath duly licensed under KRS
14 Chapter 311 that are within the scope of practice of an optometrist duly licensed
15 under the provisions of KRS Chapter 320 shall provide the same payment of
16 coverage to optometrists as allowed for those services rendered by physicians or
17 osteopaths.
- 18 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or
19 after July 12, 2006, to public employees pursuant to this section shall comply with
20 the provisions of KRS 304.17A-270 and 304.17A-525.
- 21 (23) Any ~~fully~~ insured health benefit plan or self-~~insured~~ plan issued or renewed
22 on or after July 12, 2006, to public employees shall comply with KRS 304.17A-600
23 to 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to
24 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to
25 uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641
26 pertaining to emergency medical care, KRS 304.99-123, and any administrative
27 regulations promulgated thereunder.

1 *(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or*
2 *after July 1, 2019, to public employees pursuant to this section shall comply with*
3 *Section 5 of this Act.*

4 ➔Section 8. The following KRS section is repealed:

5 194A.125 Telehealth Board -- Members -- Chair -- Scope of administrative regulations -
6 - Board to make recommendations following consultation with Governor's office --
7 Universities of Kentucky and Louisville to report to General Assembly -- Receipt
8 and dispensing of funds.

9 ➔Section 9. This Act takes effect July 1, 2019.