AN ACT relating to coverage of mental health and substance use disorders.

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

➔Section 1. KRS 304.17A-660 is amended to read as follows:

As used in KRS 304.17A-660 to ***304.17A-665***~~[304.17A-669]~~, unless the context requires otherwise:

(1) "Classification of benefits" means the classification of benefits set forth in 45 C.F.R. sec. 146.136(c)(2)(ii)(A);

(2) ***"FDA" means the United States Food and Drug Administration;***

***(3) (a) "Mental health and substance use disorder" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the most recent edition or version of:***

***1. The mental and behavioral disorders chapter of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems; or***

***2. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.***

***(b) Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders shall not affect the conditions covered by this subsection if the condition is commonly understood to be a mental health and substance use disorder by health care practitioners practicing in relevant clinical specialties***~~["Mental health condition" means any condition or disorder that involves mental illness or substance use disorder as defined in KRS 222.005 and that falls under any of the diagnostic categories listed in the most recent version of the Diagnostic~~

~~and Statistical Manual of Mental Disorders or that is listed in the mental disorders section of the most recent version of the International Classification of Disease~~];

***(4)*** ~~[(3)]~~ "Nonquantitative treatment limitation" means any limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment;

***(5)*** ~~[(4)]~~ "Terms or conditions" includes day or visit limits, episodes of care, any lifetime or annual payment limits, deductibles, copayments, prescription coverage, coinsurance, out-of-pocket limits, and any other cost-sharing requirements; and

***(6)*** ~~[(5)]~~ "Treatment of a ***mental health and substance use disorder*** ~~[mental health condition]~~" includes but is not limited to any necessary outpatient, inpatient, residential, partial hospitalization, day treatment, emergency detoxification, or crisis stabilization services.

➔SECTION 2. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-665 IS CREATED TO READ AS FOLLOWS:

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

***(a) "Generally accepted standards of mental health and substance use disorder care":***

***1. Means standards of care and clinical practice that are generally recognized by health care practitioners practicing in relevant clinical specialties, including but not limited to:***

***a. Psychiatry;***

***b. Psychology;***

***c. Clinical sociology;***

***d. Addiction medicine and counseling; and***

***e. Behavioral health treatment; and***

***2. Includes but is not limited to:***

***a. Peer-reviewed scientific studies and medical literature;***

***b. Recommendations of nonprofit health care practitioner professional associations and specialty associations, including but not limited to:***

***i. Patient placement criteria; and***

***ii. Clinical practice guidelines;***

***c. Recommendations of federal government agencies; and***

***d. Drug-labeling approved by the FDA;***

***(b) "Health plan":***

***1. Means any health insurance policy, certificate, contract, or plan that offers or provides hospital, medical, or surgical coverage in this state, whether such coverage is by direct payment, reimbursement, or otherwise; and***

***2. Includes but is not limited to:***

***a. Health benefit plans; and***

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

***(c) "Medically necessary treatment of mental health and substance use disorders" means a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:***

***1. In accordance with generally accepted standards of mental health and substance use disorder care;***

***2. Clinically appropriate in terms of type, frequency, extent, site, and***

***duration; and***

***3. Not primarily for the:***

***a. Economic benefit of the insurer or purchaser; or***

***b. Convenience of the patient, treating physician, or other health care practitioner;***

***(d) "Utilization review" has the same meaning as in KRS 304.17A-600; and***

***(e) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used to conduct a utilization review;***

***(2) Notwithstanding any other provision of law:***

***(a) All health plans shall provide coverage for medically necessary treatment of mental health and substance use disorders;***

***(b) A health plan shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of placement;***

***(c) 1. All utilization review decisions concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with one (1) or more mental health and substance use disorders shall comply with subparagraph 2.a. and b. of this paragraph.***

***2. In conducting any utilization review of health care for the diagnosis, prevention, or treatment of a mental health and substance use disorder, an insurer or any person acting on the insurer's behalf:***

***a. Shall base any medical necessity determination or utilization review criteria on generally accepted standards of mental health and substance use disorder care;***

***b. Shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the***

***nonprofit professional association for the relevant clinical specialty; and***

***c. For any utilization review involving level of care placement decisions or any other patient decisions that are within the scope of the treatment criteria referenced in subdivision b. of this subparagraph, shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the treatment criteria referenced in subdivision b. of this subparagraph.***

***3. Nothing in subparagraph 2.c. of this paragraph shall be construed to prohibit an insurer, or any person acting on the insurer's behalf, from applying utilization review criteria for the diagnosis, prevention, or treatment of a mental health and substance use disorder that:***

***a. Are outside the scope of the treatment criteria referenced in subparagraph 2.b. of this paragraph if the criteria were developed in accordance with subparagraph 2.a. of this paragraph; or***

***b. Relate to advancements in technology or types of care that are not covered in the most recent version of the criteria referenced in subparagraph 2.b. of this paragraph if the criteria were developed in accordance with subparagraph 2.a. of this subsection; and***

***(d) An insurer or any person acting on the insurer's behalf shall not:***

***1. Rescind or modify any prior authorization for mental health and substance use disorder treatment after the treatment was provided in good faith and pursuant to the prior authorization, for any reason, including a:***

***a. Subsequent rescission, cancellation, or modification of the***

***health plan; and***

***b. Subsequent determination that the insurer, or person acting on the insurer's behalf, did not make an accurate determination of the insured's eligibility for coverage; or***

***2. Adopt, impose, or enforce terms in any health plan or practitioner agreement, in writing or operation, that undermine, alter, or conflict with this section.***

➔Section 3. KRS 304.17A-661 is amended to read as follows:

(1) ***As used in this section, " Mental Health Parity and Addiction Equity Act" means the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. sec. 300gg-26, as amended, and any related federal regulations, as amended, including but not limited to 45 C.F.R. secs. 146.136, 147.160, and 156.115(a)(3).***

***(2) Notwithstanding any other provision of law, the commissioner shall implement and enforce the Mental Health Parity and Addiction Equity Act by doing, at a minimum, the following:***

***(a) Proactively ensuring compliance by individual and group health plans, including but not limited to enforcing the reporting requirements of subsection (4) of this section;***

***(b) Evaluating all consumer or practitioner complaints regarding mental health and substance use disorder benefits for possible parity violations;***

***(c) Performing parity compliance market conduct examinations of insurers, including but not limited to review of:***

***1. Nonquantitative treatment limitations, including prior authorization requirements, concurrent reviews, retrospective reviews, step therapy protocols, network admission standards, reimbursement rates, geographic restrictions, and any other nonquantitative treatment limitations deemed relevant by the commissioner;***

***2. Denials of prior authorization, payment, or coverage; and***

***3. Other specific criteria as may be determined by the commissioner; and***

***(d) Promulgating any administrative regulations in accordance with KRS Chapter 13A necessary to effectuate any provision of the Mental Health Parity and Addiction Equity Act that relates to the business of insurance.***

***(3)*** Notwithstanding any other provision of law:

(a) 1. ***All***~~[A]~~ health benefit ***plans***~~[plan issued or renewed on or after January 1, 2022,]~~ that ***provide***~~[provides]~~ coverage for treatment of a mental health ***and substance use disorder***~~[condition]~~ shall provide coverage of any treatment of a mental health ***and substance use disorder*** ~~[condition ]~~under terms or conditions that are no more restrictive than the terms or conditions provided for treatment of a physical health condition.

2. Expenses for mental health and physical health conditions shall be combined for purposes of meeting deductible and out-of-pocket limits required under a health benefit plan.

3. A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health or mental health ***and substance use disorders***~~[conditions]~~ may provide coverage for treatment of mental health ***and substance use disorder***~~[conditions]~~ through a managed care organization;

(b) With respect to mental health ***and substance use disorder***~~[condition]~~ benefits in any classification of benefits, a health benefit plan required to comply with paragraph (a) of this subsection shall not impose:

1. A nonquantitative treatment limitation that does not apply to medical and surgical benefits in the same classification; ***or***~~[and]~~

2. Medical necessity criteria or a nonquantitative treatment limitation

unless, under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the criteria or limitation to mental health ***and substance use disorder***~~[condition]~~ benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the criteria or limitation to medical and surgical benefits in the same classification; and

(c) Paragraph (b) of this subsection shall be construed to require, at a minimum, compliance with the requirements for nonquantitative treatment limitations set forth in the Mental Health Parity and Addiction Equity Act~~[ of 2008, 42 U.S.C. sec. 300gg-26, as amended, and any related federal regulations, as amended, including but not limited to 45 C.F.R. secs. 146.136, 147.160, and 156.115(a)(3)]~~.

***(4)***~~[(2)]~~ ***Notwithstanding any other provision of law:***

(a) An insurer that issues or renews a health benefit plan that is subject to the provisions of this section shall submit an annual report to the commissioner on or before April 1 of each year~~[ following January 1, 2022,]~~ that contains the following:

1. A description of the process used to develop or select the medical necessity criteria for both mental health ***and substance use disorder*** ~~[condition]~~ benefits and medical and surgical benefits;
2. Identification of all nonquantitative treatment limitations applicable to benefits and services covered under the plan that are applied to both mental health ***and substance use disorder***~~[condition]~~ benefits and medical and surgical benefits within each classification of benefits;
3. The results of an analysis that demonstrates compliance with subsection ***(3)***~~[(1)]~~(b) and (c) of this section for the medical necessity criteria

described in subparagraph 1. of this paragraph and for each nonquantitative treatment limitation identified in subparagraph 2. of this paragraph, as written and in operation. At a minimum, the results of the analysis shall:

a. Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation;

c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies:

i. Used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to mental health ***and substance use disorder*** ~~[condition]~~ benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits; and

ii. Used to apply each nonquantitative treatment limitation, in operation, for mental health ***and substance use disorder*** ~~[condition]~~ benefits are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

d. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses performed under this subparagraph indicate that the insurer is in compliance with subsection ***(3)*** ~~[(1)]~~(b) and (c) of this section; and

4. Any additional information that may be prescribed by the commissioner for use in determining compliance with the requirements of this section***;*** ***and*** ~~[.]~~

(b) The annual report shall be submitted in a manner and format prescribed by the commissioner through administrative regulation.

***(5)*** ~~[(3)]~~ ***A group health benefit plan covering fewer than fifty-one (51) employees that is not otherwise required to provide parity in mental health condition benefits under federal law shall be exempt from the provisions of this section.***

***(6)*** A willful violation of ***subsection (3) or (4) of*** this section shall constitute an act of discrimination and shall be an unfair trade practice under this chapter. The remedies provided under Subtitle 12 of this chapter shall apply to conduct in violation of this section.

➔Section 4. KRS 304.17A-665 is amended to read as follows:

***(1)*** Sixty (60) days~~[ prior to the regular session of the General Assembly in 2002, and sixty (60) days]~~ prior to each ~~[subsequent ]~~even-numbered-year regular session of the General Assembly, the commissioner shall submit a written report to the Legislative Research Commission on the impact on health insurance costs of KRS 304.17A-660 to ***304.17A-665*** ~~[304.17A-669]~~.

***(2) (a) By December 1 of each year, the commissioner shall submit a report containing the following information to the Legislative Research Commission for referral to the Interim Joint Committees on Health Services and Banking and Insurance with regard to compliance with the Mental***

***Health Parity and Addiction Equity Act and Section 5 of this Act:***

***1. The methodology the commissioner is using to determine compliance;***

***2. A list, and summary of results, of market conduct examinations conducted or completed during the preceding twelve (12) month period; and***

***3. Any educational or corrective actions the commissioner has taken to ensure compliance.***

***(b) The report required under paragraph (a) of this subsection shall be:***

***1. Written in nontechnical and readily understandable language;***

***2. Made available to the public by:***

***a. Posting the report on the department's website; and***

***b. Any other means the commissioner deems appropriate; and***

***3. Presented to the Interim Joint Committees on Health Services and Banking and Insurance upon request.***

➔SECTION 5. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-665 IS CREATED TO READ AS FOLLOWS:

***(1) As used in this section, "health plan":***

***(a) Means any health insurance policy, certificate, contract, or plan that offers or provides prescription drug coverage for the treatment of substance use disorders in this state, whether such coverage is by direct payment, reimbursement, or otherwise; and***

***(b) Includes but is not limited to:***

***1. Health benefit plans; and***

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

***(2) Notwithstanding any other provision of law, with respect to prescription drugs***

***that are on the health plan's formulary, the health plan shall:***

***(a) For any prescription drug approved by the FDA for the treatment of substance use disorders:***

***1. Not impose any prior authorization requirements;***

***2. Not impose any step therapy protocol, as defined in KRS 304.17A-163;***

***3. Place the drug on the lowest tier of the drug formulary used by the health plan; and***

***4. Not exclude coverage for the drug or any associated counseling or wraparound services based solely on the grounds that the drug, counseling, or service was court-ordered; and***

***(b) Not refuse coverage for a drug based on whether the insured participates in counseling or wraparound services.***

➔SECTION 6. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-665 IS CREATED TO READ AS FOLLOWS:

***Notwithstanding any other provision of law:***

***(1) Mental health and substance use disorder benefits shall be considered emergency benefits for the purpose of classification of benefits under a health plan, as defined in Section 2 of this Act, when treatment of a mental health and substance use disorder is provided by any of the following mental health and substance use disorder emergency practitioners:***

***(a) A crisis stabilization unit;***

***(b) A twenty-three (23) hour crisis relief center;***

***(c) An evaluation and treatment facility that:***

***1. Can provide, directly or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder; and***

***2. Is licensed or certified as such under the laws of this state;***

***(d) An agency certified under the laws of this state to provide crisis services;***

***(e) An agency certified under the laws of this state to provide medically managed or medically monitored withdrawal management services; or***

***(f) A mobile rapid response crisis team that is contracted with a behavioral health administrative services organization to provide crisis response service in the behavioral health administrative services organization's service area; and***

***(2) When a mental health and substance use disorder is treated by a mental health and substance use disorder emergency practitioner referenced in subsection (1) of this section, the mental health and substance use disorder shall be considered an emergency medical condition for purposes of this subtitle, including but not limited to KRS 304.17A-580 and 304.17A-641.***

➔SECTION 7. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-665 IS CREATED TO READ AS FOLLOWS:

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

***(a) "Health plan":***

***1. Means any health insurance policy, certificate, contract, or plan that offers or provides coverage in this state for both medical and surgical benefits and mental health and substance use disorder benefits, whether such coverage is by direct payment, reimbursement, or otherwise; and***

***2. Includes but is not limited to:***

***a. Health benefit plans; and***

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

***(b) "Mental health professional" means any of the following persons engaged in providing mental health services:***

***1. A physician or psychiatrist licensed to practice medicine or osteopathy under KRS Chapter 311;***

***2. A medical officer of the government of the United States;***

***3. A licensed psychologist, licensed psychological practitioner, certified psychologist, or licensed psychological associate, licensed under KRS Chapter 319;***

***4. A certified nurse practitioner or clinical nurse specialist with a psychiatric or mental health population focus licensed to engage in advanced practice registered nursing under KRS 314.042;***

***5. A licensed clinical social worker licensed under KRS 335.100 or a certified social worker licensed under KRS 335.080;***

***6. A licensed marriage and family therapist licensed under KRS 335.330 or a marriage and family therapist associate holding a permit under KRS 335.332;***

***7. A licensed professional clinical counselor or licensed professional counselor associate, licensed under KRS 335.500 to 335.599;***

***8. A licensed professional art therapist licensed under KRS 309.133 or a professional art therapist associate licensed under KRS 309.134;***

***9. A Kentucky licensed pastoral counselor licensed under KRS 335.600 to 335.699;***

***10. A licensed clinical alcohol and drug counselor, licensed clinical alcohol and drug counselor associate, or certified alcohol and drug counselor, licensed or certified under KRS 309.080 to 309.089; or***

***11. A physician assistant licensed under KRS 311.840 to 311.862 who meets the criteria for being a qualified mental health professional***

***under KRS 202A.011(12)(h); and***

***(c) "Mental health wellness examination" includes but is not limited to:***

***1. A behavioral health screening;***

***2. Education and consultation on healthy lifestyle changes;***

***3. Referrals to ongoing treatment, mental health services, and other supports; and***

***4. Discussion of potential options for medication.***

***(2) To the extent permitted by federal law, all health plans shall provide coverage for an annual comprehensive mental health wellness examination that is performed:***

***(a) By a mental health professional; and***

***(b) In accordance with nationally recognized clinical practice guidelines.***

***(3) The coverage required by this section shall:***

***(a) Include coverage for both in-person and telehealth examinations;***

***(b) Be no less extensive than the coverage provided for medical and surgical benefits;***

***(c) Comply with the Mental Health Parity and Addiction Equity Act; and***

***(d) Not be subject to copayments, coinsurance, deductibles, or any other cost-sharing requirements.***

➔SECTION 8. A NEW SECTION OF SUBTITLE 99 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) If the commissioner determines that an insurer, or any person acting on the insurer's behalf, has violated Section 2 of this Act, the commissioner may, after notice and hearing, by order assess a civil penalty for each violation, not to exceed:***

***(a) Except as provided in paragraph (b) of this subsection, five thousand dollars ($5,000); or***

***(b) Ten thousand dollars ($10,000) for a willful violation.***

***(2) (a) If the commissioner determines that an insurer has violated subsection (2) of Section 3 of this Act, or any administrative regulation promulgated thereunder, the commissioner may, after notice and hearing, by order, assess a civil penalty for each violation not to exceed:***

***1. Except as provided in paragraph (b) of this subsection, five thousand dollars ($5,000); or***

***2. Ten thousand dollars ($10,000) for a willful violation.***

***(b) The penalties provided under this subsection shall be cumulative to any other penalties provided under this chapter.***

➔Section 9. KRS 304.17A-265 is amended to read as follows:

(1) As used in this section:

(a) "Health insurance policy":

1. Includes any health insurance policy, certificate, plan, or contract or managed care plan, as defined in KRS 304.17A-500, regardless of whether the policy, certificate, plan, or contract was issued or delivered in this state; and

2. Does not include Medicare or Medicaid benefits;

(b) "Insurer":

1. Means any domestic, foreign, or alien insurer, self-insurer, self-insured plan, or self-insured group; and

2. Includes any domestic, foreign, or alien:

a. Health maintenance organization;

b. Limited health service organization;

c. Provider-sponsored integrated health delivery network; and

d. Nonprofit hospital, medical-surgical, dental, and health service corporation; and

(c) "Substance abuse or mental health facility" means a structurally distinct

public or private health care establishment, institution, or facility located and licensed in this state that is primarily constituted, staffed, and equipped to deliver substance abuse or mental health treatment services, or both substance abuse and mental health treatment services, to the general public.

(2) To the extent permitted under federal law, an insurer or its agent:

(a) Shall not prohibit or restrict, except as provided in paragraph (b) of this subsection, an insured under a health insurance policy from making a written assignment of any substance abuse or mental health treatment benefits available under the policy to a substance abuse or mental health facility; and

(b) May require a substance abuse or mental health facility that receives a written assignment of benefits from an insured to:

1. Provide the following information to the insured prior to performing a health care service associated with the benefits:

a. A statement informing the insured that the facility, as applicable:

i. Is an out-of-network provider;

ii. May charge the insured for services not covered under the health insurance policy; and

iii. May charge the insured the balance of any bill for services that are covered under the health insurance policy;

b. A schedule of all applicable charges for the services that the facility may provide to the insured;

c. Any terms of payment that may apply to the insured; and

d. Whether interest will apply to, and the amount of interest that will be charged against, any payment owed by the insured to the facility;

2. Submit claims associated with the benefits within ninety (90) days of the date of service;

3. Maintain records of claims associated with the benefits;

4. Respond to any inquiry regarding the benefits from an investigative unit established under KRS 304.47-080 or other similar unit; and

5. Make a good-faith effort to abide by the standards of care set forth by the following, as applicable:

a. The American Society of Addiction Medicine;

b. The American Association for Community Psychiatry's Level of Care Utilization System (LOCUS); or

c. The American Association for Community Psychiatry's and the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII).

(3) For an assignment of benefits made in accordance with this section:

(a) The assignment shall:

1. Be valid as of the effective date contained in the assignment; and

2. Remain in effect until the earlier of the following:

a. The date the insured is discharged from the care of the substance abuse or mental health facility; or

b. The date the substance abuse or mental health facility receives written notice of the insured's termination of the assignment; and

(b) Upon notice of the assignment, the insurer shall make payments directly to the substance abuse or mental health facility for all services rendered by the facility to the insured for the duration of the assignment.

(4) This section shall not be construed to:

(a) Provide a coverage or benefit that is not otherwise available under the health insurance policy;

(b) Prohibit an insurer from enforcing any terms or conditions of the health

insurance policy that are not in conflict with this section;

(c) Relieve an insured from the contractual obligation to pay deductibles, copayments, or coinsurance;

(d) Permit a substance abuse or mental health facility to waive deductibles, copayments, or coinsurance by the notice of assignment; or

(e) Violate:

1. 29 U.S.C. sec. 1185a, as amended; or

2. KRS 304.17A-660 to ***304.17A-665*** ~~[304.17A-669]~~.

➔Section 10. KRS 164.2871 (Effective January 1, 2025) is amended to read as follows:

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

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

(3) Except as provided in KRS Chapter 44, the purchase of liability insurance for

members of governing boards, faculty and staff of institutions of higher education in this state shall not be construed to be a waiver of sovereign immunity or any other immunity or privilege.

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

(a) Conform to the requirements of Subtitle 32 of KRS Chapter 304; and

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

(5) A self-insured employer group health plan provided by the governing board of a state postsecondary education institution to its employees shall comply with:

(a) KRS 304.17A-163 and 304.17A-1631;

(b) KRS 304.17A-265;

(c) KRS 304.17A-261;~~[ and]~~

(d) KRS 304.17A-262***; and***

***(e) Sections 2, 5, 6, and 7 of this Act***.

➔Section 11. KRS 205.522 is amended to read as follows:

(1) ***With respect to the administration and provision of Medicaid benefits pursuant to this chapter,*** the Department for Medicaid Services***,***~~[ and]~~ any managed care organization contracted to provide Medicaid benefits pursuant to this chapter***, and the state's medical assistance program*** shall ***be subject to, and*** comply with***,*** the ***following, as applicable:***~~[provisions of]~~

***(a)*** KRS 304.17A-163***;***~~[,]~~

***(b) KRS*** 304.17A-1631***;***~~[,]~~

***(c) KRS*** 304.17A-167***;***~~[,]~~

***(d) KRS*** 304.17A-235***;***~~[,]~~

***(e) KRS*** 304.17A-257***;***~~[,]~~

***(f) KRS*** 304.17A-259***;***~~[,]~~

***(g) KRS*** 304.17A-263***;***~~[,]~~

***(h) KRS*** 304.17A-515***;***~~[,]~~

***(i) KRS*** 304.17A-580***;***~~[,]~~

***(j) KRS*** 304.17A-600, 304.17A-603, ***and*** 304.17A-607***;***~~[, and]~~

***(k) KRS*** 304.17A-740 to 304.17A-743***; and***~~[, as applicable]~~

***(l) Sections 2, 5, 6, and 7 of this Act***.

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

➔Section 12. KRS 205.6485 is amended to read as follows:

(1) ***As used in this section, "KCHIP" means the Kentucky Children's Health Insurance Program.***

***(2)*** The Cabinet for Health and Family Services shall***:***

***(a)*** Prepare a state child health plan***, known as KCHIP,*** meeting the requirements of Title XXI of the Federal Social Security Act, for submission to the Secretary of the United States Department of Health and Human Services within such time as will permit the state to receive the maximum amounts of federal matching funds available under Title XXI***; and***~~[. The cabinet shall, ]~~

***(b)*** By administrative regulation promulgated in accordance with KRS Chapter 13A, establish the following:

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

***2.***~~[(b)]~~ The schedule of benefits to be covered by ***KCHIP*** ~~[the Kentucky Children's Health Insurance Program]~~, which shall***:***~~[ include preventive services, vision services including glasses, and dental services including at least sealants, extractions, and fillings, and which shall ]~~

***a.*** Be at least equivalent to one (1) of the following:

***i.***~~[1.]~~ The standard Blue Cross/Blue Shield preferred provider option under the Federal Employees Health Benefit Plan established by ***5*** U.S.C. sec. 8903(1);

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

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

***and***

***b. Comply with subsection (6) of this section;***

***3.***~~[(c)]~~ The premium contribution per family ***for***~~[of]~~ health insurance coverage available under ***KCHIP, which***~~[the Kentucky Children's Health Insurance Program with provisions for the payment of premium contributions by families of children eligible for coverage by the program based upon a sliding scale relating to family income. Premium contributions]~~ shall be based***:***

***a.*** On a six (6) month period***; and***

***b. Upon a sliding scale relating to family income*** not to exceed:

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

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

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

***4.***~~[(d)]~~ There shall be no copayments for services provided under ***KCHIP***~~[the Kentucky Children's Health Insurance Program]~~; and

***5. a.***~~[(e)]~~ The criteria for health services providers and insurers wishing to contract with the Commonwealth to provide ~~[the children's health insurance ]~~coverage ***under KCHIP***.

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

applicants for contracts is maximized.

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

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

***(5)***~~[(4)]~~ ***KCHIP***~~[The Kentucky Children's Health Insurance Plan]~~ shall comply with***:***

***(a)*** KRS 304.17A-163 and 304.17A-1631***; and***

***(b) Section 6 of this Act***.

***(6) The schedule of benefits required under subsection (2)(b)2. of this section shall include:***

***(a) Preventive services;***

***(b) Vision services, including glasses;***

***(c) Dental services, including sealants, extractions, and fillings; and***

***(d) The coverage required under Sections 2, 5, and 7 of this Act.***

➔Section 13. KRS 18A.225 (Effective January 1, 2025) is amended to read as follows:

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

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who

is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

2. Any certified or classified employee of a local board of education or a public charter school as defined in KRS 160.1590;

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

4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(2)(b)3. and 78.5536(2)(b)3., unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees

and retirees who are entitled to participate in the state-sponsored health insurance program;

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

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

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

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

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

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

(c) Any carrier bidding to offer health care coverage to employees shall agree to provide coverage to all members of the state group, including active employees and retirees and their eligible covered dependents and beneficiaries, within the county or counties specified in its bid. Except as provided in subsection (20) of this section, any carrier bidding to offer health care coverage to employees shall also agree to rate all employees as a single entity, except for those retirees whose former employers insure their active employees outside the state-sponsored health insurance program and as otherwise provided in KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

(d) Any carrier bidding to offer health care coverage to employees shall agree to provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance with data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions

to protect the confidentiality of each individual employee; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

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

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

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

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

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

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

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

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

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

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

department, board, agency, public postsecondary educational institution, or branch of state, city, urban-county, charter county, county, or consolidated local government shall be considered a proper cost of administration.

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

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

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

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

names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

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

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

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

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

(b) A health insurer shall not discriminate against any retail pharmacy located

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

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

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

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

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

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

(18) If a state employee's residence and place of employment are each located in counties in which the hospitals do not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic cardiac

catheterization services, and magnetic resonance imaging services, the employee may select a plan available in a county contiguous to the county of residence that does provide those services, and the state contribution for the plan shall be the amount available in the county where the plan selected is located.

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

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

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

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

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

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

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

(21) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 12, 2006, to public employees pursuant to this section which provides coverage for services rendered by a physician or osteopath duly licensed under KRS Chapter 311 that are within the scope of practice of an optometrist duly licensed under the provisions of KRS Chapter 320 shall provide the same payment of coverage to optometrists as allowed for those services rendered by physicians or osteopaths.

(22) Any fully insured health benefit plan or self-insured plan issued or renewed to public employees pursuant to this section shall comply with:

(a) KRS 304.12-237;

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

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

(d) KRS 205.593;

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

(f) KRS 304.14-135;

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

(h) KRS 304.99-123;

(i) KRS 304.17A-138;

(j) KRS 304.17A-148;

(k) KRS 304.17A-163 and 304.17A-1631;

(l) KRS 304.17A-265;

(m) KRS 304.17A-261;

(n) KRS 304.17A-262;~~[ and]~~

(o) ***Sections 2, 5, 6, and 7 of this Act; and***

***(p)*** Administrative regulations promulgated pursuant to statutes listed in this

subsection.

➔Section 14. The following KRS section is repealed:

304.17A-669 KRS 304.17A-660 to 304.17A-669 not to be construed as mandating coverage for mental health conditions -- Exemption from KRS 304.17A-660 to 304.17A-669.

➔Section 15. Sections 2, 5, 6, and 7 of this Act apply to health plans issued or renewed on or after January 1, 2026.

➔Section 16. If the state would, or would likely, be required to make payments to defray the cost of any requirement of this Act, as provided under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the Department of Insurance shall, within 90 days of the effective date of this section, apply for a waiver under 42 U.S.C. sec. 18052, as amended, or any other applicable federal law of all or any of the cost defrayal requirements.

➔Section 17. If the Cabinet for Health and Family Services determines that a waiver or any other authorization from a federal agency is necessary to implement Section 11 or 12 of this Act for any reason, including the loss of federal funds, the cabinet shall, within 90 days after the effective date of this section, request the waiver or authorization, and may only delay implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.

➔Section 18. Sections 1 to 15 of this Act take effect January 1, 2026.