AN ACT relating to coverage for hearing loss.

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

➔Section 1. KRS 304.17A-132 is amended to read as follows:

(1) As used in this section:

(a) ***"Cost sharing":***

1. Except as provided in subparagraph 2. of this paragraph, means the cost to an insured under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan; and

2. Does not include a coverage limit authorized under this section;

(b) "Hearing aid" means any ***prescription*** wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories, including earmolds, but excluding batteries and cords;~~[and]~~

(c)~~[(b)]~~ ***"Pediatric audiologist" means an audiologist licensed under KRS Chapter 334A who specializes in the diagnosis and treatment of hearing loss in children; and***

(d) "Related services" means those services necessary to assess, select, and appropriately adjust or fit the hearing aid to ensure optimal performance.

(2) ***Except as provided in subsection (3) or (5) of this section:***

(a) All~~[A]~~ health benefit ***plans***~~[plan]~~ shall provide coverage ***for hearing aids and related services in accordance with this section and administrative regulations promulgated under this section for children with hearing loss that is documented by a physician or audiologist;***

(b) The coverage required under this subsection shall include coverage, without cost sharing, for one (1) hearing aid per hard-of-hearing or deaf ear:

1. Regardless of the degree of hearing loss; and

2. That is not less than the cost of a reasonable and customary hearing aid;

(c) The commissioner shall, in consultation with the Kentucky Commission on the Deaf and Hard of Hearing:

1. Promulgate an administrative regulation in accordance with KRS Chapter 13A to establish a minimum coverage amount per hearing aid for the coverage required under this section, except a minimum coverage amount shall not be less than two thousand five hundred dollars ($2,500); and

2. Annually review the minimum coverage amount established under subparagraph 1. of this paragraph to ensure that the coverage requirements of this subsection are satisfied; and

(d) If the commissioner determines that an adjustment in the minimum coverage amount is necessary to satisfy the coverage requirements of this subsection, the commissioner shall amend the administrative regulation to make the adjustment.

(3) Notwithstanding subsection (2) of this section, the coverage required under this section shall not be less than two thousand five hundred dollars ($2,500) per~~[, subject to all applicable copayments, coinsurance, deductibles, and out-of-pocket limits, for the full cost of one (1)]~~ hearing aid ~~[per hearing impaired ear up to one thousand four hundred dollars ($1,400)]~~every thirty-six (36) months for hearing aids for insured individuals under eighteen (18) years of age and all related services which shall be prescribed by an audiologist licensed under KRS Chapter 334A and dispensed by an audiologist or hearing instrument specialist licensed under KRS Chapter 334.

(4) An~~[The]~~ insured may choose a higher priced hearing aid and may pay the difference in cost above the ***amount covered by the health benefit plan***~~[one~~

~~thousand four hundred dollar ($1,400) limit as provided in this section]~~ without any financial or contractual penalty to the insured or to the provider of the hearing aid.

(5) If the application of any requirement of this section would be the sole cause of a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied.

(6) (a) An insurer or administrator that utilizes a network to provide hearing aids and related services under a health benefit plan shall ensure that the network is reasonably adequate and accessible with respect to the provision of hearing aids and related services required to be covered under this section.

(b) A reasonably adequate and accessible network, with respect to the provision of hearing aids and related services required to be covered under this section, shall, at a minimum, offer an adequate number of accessible pediatric audiologists.

~~[(3) A health benefit plan shall not be required to pay a claim filed by its insured for payment of the cost of a hearing aid under the coverage required by subsection (2) of this section if less than three (3) years prior to the date of the claim its insured filed a claim for payment of the cost of a hearing aid under the required coverage and the claim was paid by any health benefit plan.]~~

➔Section 2. KRS 304.17A-131 is amended to read as follows:

(1) As used in this section, "cost sharing":

(a) Except as provided in paragraph (b) of this subsection, means the cost to an insured under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan; and

(b) Does not include a coverage limit authorized under this section.

(2) Except as provided in subsection (4) of this section:

(a) All health benefit plans shall provide coverage for cochlear implants ***in accordance with this section and administrative regulations promulgated under this section;***~~[for persons diagnosed with profound hearing impairment.]~~

(b) Subject to paragraph (c) of this subsection, the coverage required under this subsection shall include coverage for cochlear implants, without cost sharing, that is not less than:

1. The coverage required for cochlear implants under the federal Centers for Medicaid and Medicare's national coverage determinations for Medicare recipients; and

2. The cost of reasonable and customary cochlear implants; and

(c) Notwithstanding paragraph (b) of this subsection, the coverage required under this subsection shall not be less than the coverage that was required under this section prior to the effective date of this section.

(3) (a) The commissioner shall:

1. Promulgate an administrative regulation in accordance with KRS Chapter 13A to establish a minimum coverage amount per cochlear implant for the coverage required under subsection (2) of this section; and

2. Annually review the minimum coverage amount established in subparagraph 1. of this paragraph to ensure that the coverage requirements of subsection (2) of this section are satisfied.

(b) If the commissioner determines that an adjustment in the minimum coverage amount is necessary to satisfy the coverage requirements of subsection (2) of this section, the commissioner shall amend the

administrative regulation to make the adjustment.

(4) If the application of any requirement of this section would be the sole cause of a health benefit plan's failure to qualify as a Health Savings Account-qualified High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health benefit plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied.

➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

As used in Sections 3 to 5 of this Act:

(1) "Feeding or eating disorder":

(a) Has the same meaning as in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and

(b) Includes:

1. Anorexia nervosa;

2. Bulimia nervosa;

3. Atypical anorexia nervosa;

4. Binge-eating disorder; and

5. Any other feeding or eating disorder specified in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders; and

(2) "Health plan":

(a) Means any health insurance policy, certificate, contract, or plan that offers or provides behavioral or mental health coverage:

1. By direct payment, reimbursement, or otherwise; and

2. On a fully insured or self-insured basis or any combination thereof; and

(b) Includes:

1. A health benefit plan; 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.

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

A health plan shall provide coverage for any treatment of a diagnosed feeding or eating disorder.

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

When determining medical necessity or the appropriate level of care for an individual with a diagnosed feeding or eating disorder, a health plan that provides coverage for any treatment of a diagnosed feeding or eating disorder:

(1) Shall not utilize the following standards:

(a) Body mass index;

(b) Ideal body weight; or

(c) Any other standard requiring an achieved weight; and

(2) May rely on the following factors:

(a) Eating behaviors;

(b) The need for supervised meals and support interventions;

(c) Laboratory results of heart rate, renal or cardiovascular activity, and blood pressure;

(d) Recovery environment; and

(e) Co-occurring disorders.

➔Section 6. KRS 304.17C-125 is amended to read as follows:

The following shall apply to limited health service benefit plans, including any limited health service contract, as defined in KRS 304.38A-010:

(1) KRS 304.17A-129;

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

(3) KRS 304.17A-591 to 304.17A-599***; and***

(4) Sections 4 and 5 of this Act.

➔Section 7. 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, 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:

(a) KRS 304.17A-129;

(b) ***Sections 1 and 2 of this Act;***

(c) KRS 304.17A-145;

(d)~~[(c)]~~ KRS 304.17A-163;

(e)~~[(d)]~~ KRS 304.17A-1631;

(f)~~[(e)]~~ KRS 304.17A-167;

(g)~~[(f)]~~ KRS 304.17A-235;

(h)~~[(g)]~~ KRS 304.17A-257;

(i)~~[(h)]~~ KRS 304.17A-259;

(j)~~[(i)]~~ KRS 304.17A-263;

(k)~~[(j)]~~ KRS 304.17A-264;

(l)~~[(k)]~~ KRS 304.17A-515;

(m)~~[(l)]~~ KRS 304.17A-580;

(n)~~[(m)]~~ KRS 304.17A-600, 304.17A-603, and 304.17A-607;~~[and]~~

(o)~~[(n)]~~ KRS 304.17A-740 to 304.17A-743***; and***

(p) Sections 4 and 5 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 8. 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

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

1. The eligibility criteria for children covered by KCHIP, which shall include a provision that 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, except to the extent that Title XIX coverage is expanded by KRS 205.6481 to 205.6495 and KRS 304.17A-340;

2. The schedule of benefits to be covered by KCHIP, which shall:

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

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

iii. 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. The premium contribution per family for health insurance coverage available under KCHIP, which shall be based:

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

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

i. 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. 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. 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. There shall be no copayments for services provided under KCHIP; and

5. a. The criteria for health services providers and insurers wishing to contract with the Commonwealth to provide coverage under KCHIP.

b. The cabinet shall provide, in any contracting process for coverage of preventive services, 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 this section. The criteria shall be set forth in administrative regulations under KRS Chapter 13A and shall maximize competition among the providers and insurers. The Finance and Administration Cabinet shall provide oversight over contracting policies and procedures to assure that the number of applicants for contracts is maximized.

(3) 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) 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) KCHIP shall comply with**:**

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

(b) Section 5 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**:**

1. KRS 304.17A-129**;**

2. Sections 1 and 2 of this Act; ~~[and]~~

3. KRS 304.17A-145***; and***

4. Section 4 of this Act.

➔Section 9. KRS 164.2871 is amended to read as follows:

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

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

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

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

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

(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-129;

(b) ***Sections 1 and 2 of this Act;***

(c) KRS 304.17A-133;

(d)~~[(c)]~~ KRS 304.17A-145;

(e)~~[(d)]~~ KRS 304.17A-163 and 304.17A-1631;

(f)~~[(e)]~~ KRS 304.17A-261;

(g)~~[(f)]~~ KRS 304.17A-262;

(h)~~[(g)]~~ KRS 304.17A-264;~~[and]~~

(i)~~[(h)]~~ KRS 304.17A-265***; and***

(j) Sections 4 and 5 of this Act.

(6) (a) A self-insured employer group health plan provided by the governing board of a state postsecondary education institution to its employees shall provide a special enrollment period to pregnant women who are eligible for coverage in accordance with the requirements set forth in KRS 304.17-182.

(b) The governing board of a state postsecondary education institution shall, at or before the time an employee is initially offered the opportunity to enroll in the plan or coverage, provide the employee a notice of the special enrollment rights under this subsection.

➔Section 10. KRS 18A.225 is amended to read as follows:

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

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

sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

2. Any certified or classified employee of a local board of education 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 ***(19)*** ~~[(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.]~~

(14) ~~[(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.

(15) ~~[(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.

(16) ~~[(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.

(17) ~~[(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.

(18) ~~[(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.

(19) ~~[(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.

(20) ~~[(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.

(21) ~~[(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;

(o) KRS 304.17A-145;

(p) KRS 304.17A-129;

(q) KRS 304.17A-133;

(r) KRS 304.17A-264;~~[and]~~

(s) ***Sections 1 and 2 of this Act;***

(t) Sections 4 and 5 of this Act; and

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

(22)~~[(23)]~~ (a) Any fully insured health benefit plan or self-insured plan issued or renewed to public employees pursuant to this section shall provide a special enrollment period to pregnant women who are eligible for coverage in accordance with the requirements set forth in KRS 304.17-182.

(b) The Department of Employee Insurance shall, at or before the time a public employee is initially offered the opportunity to enroll in the plan or coverage, provide the employee a notice of the special enrollment rights under this subsection.

➔Section 11. Sections 1, 2, 3, 4, 5, 6, 9, and 10 of this Act apply to health plans issued or renewed on or after January 1, 2026.

➔Section 12. (1) For purposes of 45 C.F.R. sec. 155.170, the benefits required under KRS 304.17A-131 and 304.17A-132 prior to the effective date of Sections 1 and 2 of this Act shall be considered by the state as "[a] benefit required by state action taking place on or before December 31, 2011" and thus the state shall not consider or identify the benefits required under KRS 304.17A-131 and 304.17A-132 prior to the effective date of Sections 1 and 2 of this Act as being in addition to the essential health benefits required under federal law.

(2) The commissioner of insurance and any other state official or state agency shall:

(a) Comply with the requirements of this section; and

(b) Not take any action that is in violation of or in conflict with this section.

➔Section 13. Notwithstanding KRS 194A.099:

(1) Within 90 days of the effective date of this section and subject to Section 12 of this Act, the Department of Insurance shall identify, in accordance with 45 C.F.R. sec. 155.170(a)(3), whether the application of any requirement of subsection (2) of Section 1 of this Act or subsection (2) of Section 2 of this Act to a qualified health plan (QHP) is in addition to the essential health benefits required under federal law; and

(2) If it is determined that the application of any requirement of subsection (2) of Section 1 of this Act or subsection (2) of Section 2 of this Act to a QHP is in addition to the essential health benefits required under federal law, then the department shall, within 180 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 under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended.

➔Section 14. If the Department for Medicaid Services or the Cabinet for Health and Family Services determines that a state plan amendment, waiver, or any other form of authorization or approval from any federal agency is necessary prior to implementation of Section 7 or 8 of this Act for any reason, including the loss of federal funds, the department or cabinet shall, within 90 days after the effective date of this section, request any necessary state plan amendment, waiver, authorization, or approval, and may only delay full implementation of those provisions for which a state plan amendment, waiver, authorization, or approval was deemed necessary until the state plan amendment, waiver, authorization, or approval is granted or approved.

➔Section 15. The Department for Medicaid Services or the Cabinet for Health and Family Services shall, in accordance with KRS 205.525, provide a copy of any state plan amendment, waiver application, or other request for authorization or approval submitted pursuant to Section 14 of this Act to the Legislative Research Commission for referral to the Interim Joint Committees on Health Services and Appropriations and

Revenue and shall provide an update on the status of any application or request submitted pursuant to Section 14 of this Act at the request of the Legislative Research Commission or any committee thereof.

➔Section 16. Sections 1 to 11 of this Act take effect January 1, 2026.