AN ACT relating to coverage for the care of children.

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

➔Section 1. KRS 304.17A-258 is amended to read as follows:

(1) ***As used in*** ~~[For purposes of]~~ this section:

(a) "Therapeutic food, formulas, and supplements" means products intended for the dietary treatment of inborn errors of metabolism or genetic conditions, including but not limited to eosinophilic disorders, food protein allergies, food protein-induced enterocolitis syndrome, mitochondrial disease, and short bowel disorders, under the direction of a physician, and includes amino acid-based elemental formula and the use of vitamin and nutritional supplements such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2, vitamin K1, and L-carnitine;

(b) "Low-protein modified food" means a product formulated to have less than one (1) gram of protein per serving and intended for the dietary treatment of inborn errors of metabolism or genetic conditions under the direction of a physician; and

(c) "Amino acid-based elemental formula" means a product intended for the diagnosis and dietary treatment of eosinophilic disorders, food protein allergies, food protein-induced enterocolitis, and short ***bowel*** ~~[bowel]~~ syndrome under the direction of a physician.

(2) ***(a)*** A health benefit plan that provides prescription drug coverage shall include in that coverage therapeutic food, formulas, supplements, and low-protein modified food products for the treatment of inborn errors of metabolism or genetic conditions, including those that are compounded, if the therapeutic food, formulas, supplements, and low-protein modified food products are obtained for the therapeutic treatment of inborn errors of metabolism or genetic conditions, including but not limited to mitochondrial disease, under

the direction of a physician.

(b) Except as provided in subsection (4) of this section, coverage under this subsection may be subject, for each plan year, to a cap of twenty-five thousand dollars ($25,000) for therapeutic food, formulas, and supplements and a separate cap for each plan year of four thousand dollars ($4,000) ***for*** ~~[on]~~ low-protein modified foods.~~[Each cap shall be subject to annual inflation adjustments based on the consumer price index.]~~

(c) Coverage under this ***subsection*** ~~[section]~~ shall not be denied because two (2) or more supplements are compounded.

(3) ***(a) To the extent that coverage is not provided under subsection (2) of this section or KRS 304.17A-139, a health benefit plan shall provide coverage for enteral infant and baby formulas prescribed by a physician in a written order, which states that the formula:***

1. Is medically necessary; and

2. Has been proven effective as a disease-specific treatment regimen ~~[The requirements of this section shall apply to all health benefit plans issued or renewed on and after January 1, 2017]~~.

(b) Except as provided in subsection (4) of this section, coverage under this subsection may be subject to, for each plan year, a cap of three thousand dollars ($3,000).

(4) ***Any cap imposed on coverage required under subsection (2) or (3) of this section shall be subject to annual inflation adjustments based on the nonseasonally adjusted annual average Consumer Price Index for All Urban Consumers (CPI-U), U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics*** ~~[Nothing in this section or KRS 205.560, 213.141, or 214.155 shall be construed to require a health benefit plan to provide coverage for therapeutic foods, formulas, supplements, or low-protein modified food for the treatment of~~

~~lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other condition or disease that is not an inborn error of metabolism or genetic condition~~].

(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) Notwithstanding KRS 304.17A-099 and any other provision of this chapter, if the application of any requirement of this section to a qualified health plan, as defined in 42 U.S.C. sec. 18021(a)(1), as amended, results, or would result, in a determination that the state must make payments to defray the cost of the requirement under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the requirement shall not apply to the qualified health plan until the requirement to make cost defrayal payments is no longer applicable.

➔Section 2. KRS 304.17A-145 is amended to read as follows:

(1) As used in this section:

(a) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except for purposes of this section, the term:

1. Includes student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure; and

2. Does not include a group health benefit plan that provides grandfathered health plan coverage as defined in 45 C.F.R. sec. 147.140(a), as amended;

(b) "In-home program" means a program offered by a health care facility or health care professional for the treatment of substance use disorder which the insured accesses through telehealth or digital health services; and

(c) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.

(2) Except as provided for in subsection (5) of this section:

(a) A health benefit plan shall provide maternity coverage; and

(b) The coverage required by this subsection includes coverage for:

1. All individuals covered under the plan, including dependents, regardless of age;

2. Maternity care associated with pregnancy, childbirth, and postpartum care;

3. Labor and delivery;

4. ***In conjunction with each birth and without a prescription,*** all breastfeeding services and supplies required under 42 U.S.C. sec. 300gg-13(a) and any related federal regulations, as amended; and

5. Except as provided in subsection (3) of this section, inpatient care for a mother and her newly born child for a minimum of:

a. Forty-eight (48) hours after vaginal delivery; or

b. Ninety-six (96) hours after delivery by Cesarean section.

(3) The provisions of subsection (2)(b)5. of this section shall not apply to a health benefit plan if:

(a) The plan authorizes an initial postpartum home visit which would include the collection of an adequate sample for the hereditary and metabolic newborn screening; and

(b) The attending physician, with the consent of the mother of the newly born child, authorizes a shorter length of stay upon the physician's determination that the mother and newborn meet the criteria for medical stability in the most current version of "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

(4) Except as provided for in subsection (5) of this section, a health benefit plan shall provide coverage:

(a) To pregnant and postpartum women for an in-home program; and

(b) For telehealth or digital health services that are related to maternity care associated with pregnancy, childbirth, and postpartum care.

(5) If the application of any requirement of this section to a qualified health plan as defined in 42 U.S.C. sec. 18021(a)(1), as amended, would result in a determination that the state must make payments to defray the cost of the requirement under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the requirement shall not apply to the qualified health plan until the cost defrayal requirement is no longer applicable.

➔Section 3. 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) KRS 304.17A-145;

(c) KRS 304.17A-163;

(d) KRS 304.17A-1631;

(e) KRS 304.17A-167;

(f) KRS 304.17A-235;

(g) KRS 304.17A-257;

(h) KRS 304.17A-259;

(i) KRS 304.17A-263;

(j) KRS 304.17A-264;

(k) KRS 304.17A-515;

(l) KRS 304.17A-580;

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

(n) KRS 304.17A-740 to 304.17A-743***; and***

(o) Section 1 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 4. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health and family services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including but not limited to the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include ***those*** products ***covered under Section 1 of this Act***~~[for the treatment of inborn errors of metabolism or genetic, gastrointestinal, and food allergic conditions, consisting of therapeutic food, formulas, supplements, amino acid-based elemental formula, or low-protein modified food products that are medically indicated for therapeutic treatment and are administered under the direction of a physician,]~~ and include but ~~[are]~~not ***be*** limited to ***products for*** the following conditions:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-CoA carboxylase deficiency;
8. 3-methylglutaconyl-CoA hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. Non-ketotic hyperglycinemia;

15. Propionic acidemia;
16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthetase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic aciduria;
22. Methylmalonic acidemia;
23. Argininemia;
24. Food protein allergies;
25. Food protein-induced enterocolitis syndrome;
26. Eosinophilic disorders; and
27. Short bowel syndrome;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent; and

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed

physician who rotates his ***or her*** services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health and Family Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

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

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

(c) Salaries paid to immediate family members of the owner or administrator, or

both, of a facility, to the extent that services are not actually performed and are not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health and Family Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

(e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services; and

(f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship between the facility and the supplier exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business. An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the Cabinet for Health and Family Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.

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

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

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

physician's supervision.

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

(b) Except as provided in KRS 210.370(4) and (5)(c), if a community mental health center, established pursuant to KRS Chapter 210, provides services to a recipient of Medical Assistance Program benefits outside of the community mental health center's regional service area, as established in KRS 210.370, the community mental health center shall not be reimbursed for such services in accordance with the department's fee schedule for community mental health centers but shall instead be reimbursed in accordance with the department's fee schedule for behavioral health service organizations.

(c) As used in this subsection, "community mental health center" means a regional community services program as defined in KRS 210.005.

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

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

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

(12) (a) The Medical Assistance Program shall use the appropriate form and guidelines for enrolling those providers applying for participation in the Medical Assistance Program, including those licensed and regulated under KRS Chapters 311, 312, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care practitioner or facility as determined by the Department for Medicaid Services through an administrative regulation promulgated under KRS Chapter 13A. A Medicaid managed care organization shall use the forms and guidelines established under KRS 304.17A-545(5) to credential a provider. For any provider who contracts with and is credentialed by a Medicaid managed care organization prior to enrollment, the cabinet shall complete the enrollment process and deny, or approve and issue a Provider Identification Number (PID) within fifteen (15) business days from the time all necessary completed enrollment forms have been submitted and all outstanding accounts receivable have been satisfied.

(b) Within forty-five (45) days of receiving a correct and complete provider application, the Department for Medicaid Services shall complete the enrollment process by either denying or approving and issuing a Provider

Identification Number (PID) for a behavioral health provider who provides substance use disorder services, unless the department notifies the provider that additional time is needed to render a decision for resolution of an issue or dispute.

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

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

(e) The Department of Insurance may impose a civil penalty of one hundred dollars ($100) per violation when a Medicaid managed care organization fails to comply with this section. Each day that a Medicaid managed care organization fails to pay a claim may count as a separate violation.

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

➔Section 5. 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 KRS 304.17A-163 and 304.17A-1631.

(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***;*** ~~[and]~~

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

3. Section 1 of this Act.

➔Section 6. 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) KRS 304.17A-133;

(c) KRS 304.17A-145;

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

(e) KRS 304.17A-261;

(f) KRS 304.17A-262;

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

(h) KRS 304.17A-265***; and***

(i) Section 1 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 7. 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.

(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.

(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) Section 1 of this Act; and

(t)~~[(s)]~~ 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 8. Sections 1, 2, 6, and 7 of this Act apply to health benefit plans issued or renewed on or after January 1, 2026.

➔Section 9. 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 a federal agency is necessary prior to implementation of Section 3, 4, or 5 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 10. 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 9 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 9 of this Act at the request of the Legislative Research Commission or any committee thereof.

➔Section 11. Sections 1 to 8 of this Act take effect January 1, 2026.