AN ACT relating to reproductive health services.

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

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 211 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Contraception" means an action taken to prevent pregnancy, including the use of contraceptives or fertility-awareness based methods and sterilization procedures; and

(b) "Contraceptive" means any drug, device, or biological product intended for use in the prevention of pregnancy, whether specifically intended to prevent pregnancy or for other health needs, that is legally marketed under the Federal Food, Drug, and Cosmetic Act, such as oral contraceptives, long-acting reversible contraceptives, emergency contraceptives, internal and external condoms, injectables, vaginal barrier methods, transdermal patches, and vaginal rings, or other contraceptives.

(2) Notwithstanding any other provision of law to the contrary, a person has a statutory right to obtain contraceptives and to engage in contraception, and a health care provider practicing in any place in the Commonwealth, including institutions of higher education, has a corresponding right to provide contraceptives, contraception, referrals, services, and information related to contraception.

(3) The statutory rights specified in subsection (2) of this section shall not be limited or otherwise infringed upon through any limitation or requirement that:

(a) Expressly, effectively, implicitly, or as implemented singles out:

1. The provision or sale of contraceptives, contraception, or information related to contraception;

2. Health care providers who provide or dispense contraceptives,

contraception, or information related to contraception; or

3. Facilities in which contraceptives, contraception, or information related to contraception is provided or dispensed; or

(b) Impedes or prohibits the sale or access to contraceptives, contraception, or information related to contraception.

(4) To defend against a claim that a limitation or requirement violates a health care provider's or patient's rights under subsection (2) of this section, a party must establish by clear and convincing evidence that:

(a) The limitation or requirement significantly advances access to contraceptives, contraception, and information related to contraception; and

(b) Access to contraceptives, contraception, and information related to contraception or the health of patients cannot be advanced by a less restrictive alternative measure or action.

(5) The Commonwealth or its localities shall not administer, implement, or enforce any law, administrative regulation, or other provision having the force and effect of law that conflicts with any provision of this section, notwithstanding any provision of federal law, including the Religious Freedom Restoration Act of 1993, including:

(a) Prohibiting or restricting the sale, provision, or use of any contraceptives;

(b) Prohibiting or restricting any individual from aiding another individual in voluntarily obtaining or using any contraceptives or contraception; or

(c) Exempting any contraceptives or contraception from any other generally applicable law in a way that would make it more difficult to sell, provide, obtain, or use such contraceptives or contraception, including over-the-counter sales.

(6) The Attorney General may commence a civil action on behalf of the

Commonwealth against any locality that implements or enforces any limitation or requirement that violates this section, or against any person who implements or enforces any limitation or requirement that violates this section. The court shall hold unlawful and set aside the limitation or requirement if it is in violation of this section.

(7) The following private rights of action shall be available under this section:

(a) Any individual or entity, including any health care provider or patient, adversely affected by an alleged violation of this section may commence a civil action against the Commonwealth or any locality that implements or enforces any limitation or requirement that violates this section or against any person who implements or enforces any limitation or requirement that violates this section; and

(b) A health care provider may commence an action for relief on its own behalf, on behalf of the provider's staff, and on behalf of the provider's patients who are or may be adversely affected by an alleged violation of this section.

(8) In any action under this section, the court may award appropriate equitable relief, including temporary, preliminary, or permanent injunctive relief.

(9) In any action under this section, the court shall award costs of litigation, as well as reasonable attorney fees, to any prevailing plaintiff. A plaintiff shall not be liable to a defendant for costs or attorney's fees in any nonfrivolous action under this section.

(10) An action under this section shall be filed in Circuit Court. The Circuit Court shall exercise jurisdiction without regard to whether the aggrieved party has exhausted any administrative or other remedies that may be provided for by law.

(11) A locality that enforces or maintains any limitation or requirement that violates this section, or a government official, including any person who is permitted to

implement or enforce any limitation or requirement that violates this section, shall not be immune from an action challenging that limitation or requirement.

➔SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

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

(b) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except for purposes of this section, the term shall include student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure;

(c) "Long-acting reversible contraception":

1. Means a contraception method that requires administration less than once per month; and

2. Includes:

a. An intrauterine device; and

b. A contraceptive implant; and

(d) "Religious employer" means an organization that is:

1. Organized and operates as a nonprofit entity; and

2. Referred to in 26 U.S.C. sec. 6033(a)(3)(A)(i) or (iii), as amended.

(2) Except as otherwise provided in subsection (3) or (5) of this section, a health benefit plan shall provide coverage for the following:

(a) All FDA-approved contraceptive drugs, devices, and products, including:

1. Those prescribed:

a. By a covered person's provider; or

b. As otherwise authorized under state and federal law;

2. Over-the-counter contraceptive drugs, devices, and products;

3. Those dispensed on-site at a provider's office, if available; and

4. Long-acting reversible contraception administered during a postpartum stay;

(b) Voluntary sterilization procedures;

(c) Patient education and counseling on contraception; and

(d) Follow-up services related to drugs, devices, products, and procedures covered under this section, including but not limited to:

1. Management of side effects;

2. Counseling for continued adherence; and

3. Device insertion and removal.

(3) For the coverage required under subsection (2)(a) of this section, the health benefit plan shall:

(a) If the FDA has designated a therapeutic equivalent of an FDA-approved prescription contraceptive drug, device, or product, cover either:

1. The original FDA-approved prescription contraceptive drug, device, or product; or

2. At least one (1) therapeutic equivalent of the original FDA-approved prescription contraceptive drug, device, or product;

(b) If a contraceptive drug, device, or product is deemed medically inadvisable by the covered person's provider, defer to the determination and judgment of the provider and provide coverage for an alternate prescribed FDA-approved contraceptive drug, device, or product;

(c) Provide coverage for the supply of contraceptives intended to last over a twelve (12) month duration, which, at the discretion of the provider, may be furnished or dispensed all at once or over the course of twelve (12) months;

(d) Reimburse a provider or dispensing entity per unit for furnishing or dispensing an extended supply of contraceptives;

(e) Not deny the coverage required under this section because a covered person

changed contraceptive methods within a twelve (12) month period; and

(f) Not require a prescription to trigger the coverage of FDA-approved over-the-counter contraceptive drugs, devices, and products.

(4) A health benefit plan subject to the coverage requirements of this section:

(a) Shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage, unless the health benefit plan is offered as a qualifying high deductible health plan for a health savings account, in which case the plan shall establish cost-sharing only at the minimum level necessary to preserve the covered person's ability to claim tax-exempt contributions and withdrawals from the person's health savings account under 26 U.S.C. sec. 223, as amended;

(b) Except as otherwise authorized under this section, shall not impose any restrictions or delays on the coverage; and

(c) Shall provide the same level of benefits to a covered person's covered dependents as the plan provides to the covered person.

(5) (a) A religious employer may request a health benefit plan without coverage for any FDA-approved drugs, devices, products, procedures, and services used for contraceptive purposes that are contrary to the religious employer's religious tenets.

(b) A religious employer that makes a request under paragraph (a) of this subsection shall:

1. Be provided a health benefit plan without the contraceptive coverage; and

2. Provide written notice to each prospective covered person, prior to the covered person's enrollment in the health benefit plan, listing the contraceptive drugs, devices, products, procedures, and services the employer refused to cover for religious reasons.

(6) Nothing in this section shall be construed to:

(a) Exclude coverage for contraceptive drugs, devices, and products prescribed by a provider, acting within the provider's scope of practice, for reasons other than contraceptive purposes, including but not limited to:

1. Decreasing the risk of ovarian cancer;

2. Eliminating symptoms of menopause; or

3. Contraception that is necessary to preserve the life of the covered person; or

(b) Require a health benefit plan to cover experimental or investigational treatments.

➔Section 3. KRS 304.17A-099 is amended to read as follows:

(1) As used in this section, "qualified health plan" has the same meaning as in 42 U.S.C. sec. 18021(a)(1), as amended.

(2) Notwithstanding any other provision of this chapter:

(a) Except as provided in paragraph (b) of this subsection, if the application of a provision of this chapter results, or would result, in a determination that the state must make payments to defray the cost of the provision under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the provision shall not apply to a qualified health plan or any other health insurance policy, certificate, plan, or contract until the requirement to make cost defrayal payments is no longer applicable; and

(b) This subsection shall not apply to***:***

1. A provision of this chapter that became effective on or before January 1, 2024***; or***

2. Section 2 of this Act.

(3) To the extent permitted by federal law, if the state is required under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, to make payments to defray

the cost of a provision of this chapter:

(a) 1. Each qualified health plan issuer shall determine, and provide to the commissioner, the cost attributable to the provision for the qualified health plan.

2. The cost attributable to a provision for a qualified health plan under subparagraph 1. of this paragraph shall be:

a. Calculated in accordance with generally accepted actuarial principles and methodologies;

b. Conducted by a member of the American Academy of Actuaries; and

c. Reported by the qualified health plan issuer to:

i. The commissioner; and

ii. The Division of Health Benefit Exchange within the Office of Data Analytics;

(b) The commissioner shall use the information obtained under paragraph (a) of this subsection to determine the statewide average of the cost attributable to the provision for all qualified health plan issuers to which the provision is applicable; and

(c) The required payments shall be:

1. Calculated based on the statewide average of the cost attributable to the provision as determined by the commissioner under paragraph (b) of this subsection; and

2. Submitted directly to qualified health plan issuers by the department through a process established by the commissioner.

(4) A qualified health plan issuer that receives a payment under subsection (3)(c)2. of this section shall:

(a) Reduce the premium charged to an individual on whose behalf the issuer

received the payment in an amount equal to the amount of the payment; or

(b) Notwithstanding KRS 304.12-090, provide a premium rebate to an individual on whose behalf the issuer received the payment in an amount equal to the amount of the payment.

(5) Any fines collected for violations of this section shall be:

(a) Placed in a trust and agency account within the department, which shall not lapse; and

(b) Used solely by the department to make payments in accordance with subsection (3)(c)2. of this section.

(6) The commissioner shall promulgate any administrative regulations necessary to enforce and effectuate this section.

➔Section 4. KRS 164.2871 (Effective January 1, 2025) is amended to read as follows:

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

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

January 1, 1998, shall be subject to the tax imposed by KRS 141.020, to the extent provided in KRS 141.010 and 141.0215.

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

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

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

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

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

(a) KRS 304.17A-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 2 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 5. KRS 205.522 (Effective January 1, 2025) 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 2 of this Act, except subsection (4)(c) of Section 2 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 6. KRS 205.6485 (Effective January 1, 2025) 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 2 of this Act, except subsection (4)(c) of Section 2 of this Act.

➔Section 7. KRS 18A.225 (Effective January 1, 2025) is amended to read as follows:

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

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;
2. Any certified or classified employee of a local board of education or a public charter school as defined in KRS 160.1590;
3. Any elected member of a local board of education;
4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, County Employees Retirement System, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the

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

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

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

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

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

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

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

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

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

(d) Any carrier bidding to offer health care coverage to employees shall agree to provide enrollment, claims, and utilization data to the Commonwealth in a format specified by the Personnel Cabinet with the understanding that the data shall be owned by the Commonwealth; to provide data in an electronic form and within a time frame specified by the Personnel Cabinet; and to be subject to penalties for noncompliance with data reporting requirements as specified by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions to protect the confidentiality of each individual employee; however, confidentiality assertions shall not relieve a carrier from the requirement of providing stipulated data to the Commonwealth.

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

(f) If any agency participating in the state-sponsored employee health insurance program for its active employees terminates participation and there is a state

appropriation for the employer's contribution for active employees' health insurance coverage, then neither the agency nor the employees shall receive the state-funded contribution after termination from the state-sponsored employee health insurance program.

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

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

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

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

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

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

(4) If an employee moves his or her place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he or she has elected coverage, into either the service area of another managed health care plan or into an area of the Commonwealth not within a managed health care plan

service area, the employee shall be given an option, at the time of the move or transfer, to change his or her coverage to another health benefit plan.

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

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

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

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

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or the secretary's designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age

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

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

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

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

the extent needed for purchase of one (1) state sponsored health insurance policy for that plan year.

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

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

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

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

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

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

(17) If a state employee's residence and place of employment are in the same county, and if the hospital located within that county does not offer surgical services, intensive care services, obstetrical services, level II neonatal services, diagnostic

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

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

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

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

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

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

(c) The request for proposal shall require a carrier's bid to include every county

within the region or regions for which the bid is submitted and include but not be restricted to a preferred provider organization (PPO) option;

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

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

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

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

(a) KRS 304.12-237;

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

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

(d) KRS 205.593;

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

(f) KRS 304.14-135;

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

(h) KRS 304.99-123;

(i) KRS 304.17A-138;

(j) KRS 304.17A-148;

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

(l) KRS 304.17A-265;

(m) KRS 304.17A-261;

(n) KRS 304.17A-262;

(o) KRS 304.17A-145;

(p) KRS 304.17A-129;

(q) KRS 304.17A-133;

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

(s) ***Section 2 of this Act; and***

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

(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. KRS 446.350 is amended to read as follows:

(1) Government shall not substantially burden a person's freedom of religion. The right to act or refuse to act in a manner motivated by a sincerely held religious belief may not be substantially burdened unless the government proves by clear and convincing evidence that it has a compelling governmental interest in infringing the specific act or refusal to act and has used the least restrictive means to further that interest. A "burden" shall include indirect burdens such as withholding benefits,

assessing penalties, or an exclusion from programs or access to facilities.

(2) Nothing in Section 1, 2, or 9 of this Act shall be construed to be in violation of this section.

➔SECTION 9. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Family planning services":

1. Means family planning services that are provided under the Medicaid program;

2. Includes:

a. Sexual health education and family planning counseling; and

b. Other medical diagnosis, treatment, or preventive care routinely provided as part of a family planning service visit; and

3. Does not include an elective abortion, as defined in KRS 304.5-160; and

(b) "Low-income individual" means an individual who:

1. Has an income level that is equal to or below ninety-five percent (95%) of the federal poverty level; and

2. Does not qualify for full coverage under the Medicaid program.

(2) Within ninety (90) days of the effective date of this section, the Cabinet for Health and Family Services shall apply for a waiver or a state plan amendment with the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services to:

(a) Offer a program that provides family planning services to low-income individuals; and

(b) Receive a federal match rate of ninety percent (90%) of state expenditures for family planning services provided under the waiver or state plan

amendment.

(3) If the waiver or state plan amendment described in subsection (2) of this section is approved, the Cabinet for Health and Family Services shall report to the Legislative Research Commission, while the waiver or state plan amendment is in effect, annually before November 30, the following:

(a) The number of qualified individuals served under the program;

(b) The cost of the program; and

(c) The effectiveness of the program, including any:

1. Savings to the Medicaid program from reduction in enrollment;

2. Reduction in the number of abortions;

3. Reduction in the number of unintended pregnancies;

4. Reduction in the number of individuals requiring services from the program for women, infants, and children established in 42 U.S.C. sec. 1786; and

5. Other costs and benefits as a result of the program.

➔SECTION 10. A NEW SECTION OF KRS CHAPTER 315 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "hormonal contraceptive" means a self-administered drug, or a transdermal patch applied to the skin of a patient by the patient or by a practitioner, that releases a drug composed of a combination of hormones approved by the United States Food and Drug Administration to prevent pregnancy.

(2) A pharmacist, acting in good faith, is authorized to provide hormonal contraceptives according to a valid collaborative care agreement containing a nonpatient-specific prescriptive order and standardized procedures developed and executed by one (1) or more authorized prescribers.

(3) The board, in collaboration with the Kentucky Board of Medical Licensure, shall

promulgate administrative regulations in accordance with KRS Chapter 13A to establish standard procedures for the provision of hormonal contraceptives by pharmacists. The standard procedures adopted pursuant to this section shall require a pharmacist to:

(a) Complete a training program approved by the Cabinet for Health and Family Services related to the provision of hormonal contraceptives;

(b) Provide the patient with a self-screening risk assessment tool developed or approved by the Cabinet for Health and Family Services;

(c) Provide the patient with documentation about the hormonal contraceptive that was provided to the patient and advise the patient to consult with a primary care practitioner or women's healthcare practitioner;

(d) Provide the patient with a standardized factsheet that includes but is not limited to the indications and contraindications for use of the drug, appropriate method for using the drug, importance of a medical follow-up, and other appropriate information;

(e) Provide the patient with the contact information of a primary care practitioner or women's healthcare practitioner within a reasonable period of time after provision of the hormonal contraceptive; and

(f) Either dispense the hormonal contraceptive or refer the patient to a pharmacy that may dispense the hormonal contraceptive as soon as practicable after the pharmacist determines that the patient should receive the medication.

(4) The administrative regulations promulgated under this section shall prohibit a pharmacist from requiring a patient to schedule an appointment with the pharmacist for the provision or dispensing of a hormonal contraceptive.

(5) (a) A pharmacist or the pharmacist's employer or agent may charge the annual administrative fee for services provided pursuant to this section in addition

to any costs associated with the dispensing of the drug and paid by the pharmacy insurance benefit.

(b) Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total cost that a consumer would pay for pharmacist-provided hormonal contraceptives. As used in this paragraph, "total cost" includes providing the consumer with specific information regarding the price of the hormonal contraceptive and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist or a pharmacist's employer or agent and a health insurance plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of hormonal contraceptives shall not be required to pay an administrative fee but may be required to pay copayments pursuant to the terms and conditions of their coverage.

(6) All state and federal laws governing insurance coverage of contraceptive drugs, devices, products, and services shall apply to hormonal contraceptives provided by a pharmacist under this section.

(7) The board and the Kentucky Board of Medical Licensure shall ensure compliance with this section, and each board is specifically charged with the enforcement of this section with respect to its respective licensees.

(8) Any pharmacist or prescriber acting in good faith and with reasonable care involved in the provision of hormonal contraceptives pursuant to this section shall be immune from disciplinary or adverse administrative actions under this chapter for acts or omissions related to the provision of a hormonal contraceptive.

(9) A pharmacist or prescriber involved in the provision of hormonal contraceptives pursuant to this section shall be immune from civil liability unless the injury

results from the gross negligence or willful misconduct of the pharmacist or provider.

(10) This section shall not apply to a valid patient-specific prescription for a hormonal contraceptive issued by an authorized prescriber and dispensed by a pharmacist pursuant to the valid prescription.

➔Section 11. Sections 2, 4, and 7 of this Act apply to health benefit plans issued, renewed, amended, effective, or delivered on or after January 1, 2026.

➔Section 12. Sections 2, 3, 4, 5, 6, and 7 of this Act take effect January 1, 2026.

➔Section 13. (1) For purposes of 45 C.F.R. sec. 156.115, the benefits required under Section 2 of this Act are intended to be, and shall be considered, substantially equal to the benefits required under the state's EHB-benchmark plan.

(2) For purposes of 45 C.F.R. sec. 155.170, the benefits required under Section 2 of this Act are intended to be, and shall be considered by the state as, a benefit required by State action "for purposes of compliance with Federal requirements," and thus, the state shall not consider or identify the benefits required under Section 2 of this Act as being in addition to the essential health benefits required under federal law.

(3) The "Federal requirements" referred to in subsection (2) of this section include the requirement to provide coverage for preventive health services under 42 U.S.C. sec. 300gg-13.

(4) 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 14. Notwithstanding KRS 194A.099:

(1) Within 90 days of the effective date of this section and subject to Section 13 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 Section 2 of this Act to a

qualified health plan (QHP) is in addition to the essential health benefits required under federal law.

(2) If it is determined that the application of any requirement 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.

(3) The application required under subsection (2) of this section:

(a) Shall comply with the requirements of federal law for obtaining a waiver; and

(b) May propose changes to the state's EHB-benchmark plan, as defined in 45 C.F.R. sec. 156.20, that are not in conflict with existing state law.

➔Section 15. If the Cabinet for Health and Family Services determines that a waiver or any other authorization from a federal agency is necessary to implement any provision of this Act for any reason, including the loss of federal funds, the Cabinet shall, within 90 days after the effective date of this section, request the waiver or authorization, and may only delay implementation of those provisions for which a waiver or authorization was deemed necessary until the waiver or authorization is granted.