AN ACT relating to coverage for mental health or substance use disorders.

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

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

As used in KRS 304.17A-660 to 304.17A-669, unless the context requires otherwise:

(1) "Classification of benefits"***:***

(a) Means the classification of benefits set forth in 45 C.F.R. sec. 146.136(c)(2)(ii)(A)***, as amended***; ***and***

(b) Includes but is not limited to the following classifications as applied to both in-network and out-of-network benefits:

1. Inpatient;

2. Outpatient;

3. Emergency care; and

4. Prescription drugs;

(2) "Mental health ***or substance use disorder*** condition" means any condition or disorder that***:***

(a) Involves mental illness or substance use disorder as defined in KRS 222.005***;*** and~~[that]~~

(b) 1. Falls under any of the diagnostic categories listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders***;*** or~~[that]~~

2. Is listed in the mental disorders section of the most recent version of the International Classification of Disease;

(3) "Nonquantitative treatment limitation"***:***

(a) Means any limitation that is not expressed numerically but otherwise limits the scope or duration of benefits for treatment***; and***

(b) Includes but is not limited to:

1. Prior authorization requirements;

2. Standards relating to network composition; and

3. Methodologies used to determine out-of-network reimbursement rates;

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

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

➔Section 2. KRS 304.17A-661 is amended to read as follows:

(1) Notwithstanding any other provision of law:

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

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

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

(b) With respect to mental health ***or substance use disorder*** condition benefits in any classification of benefits, a health benefit plan required to comply with

paragraph (a) of this subsection shall not impose:

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

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

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

(d) This subsection shall apply to:

1. Each insurer that offers or provides a health benefit plan that is subject to this section; and

2. The designee or agent of an insurer referenced in subparagraph 1. of this paragraph.

(2) (a) ***In order to ensure compliance with this section,*** an insurer that ***offers or provides***~~[issues or renews]~~ a health benefit plan that is subject to ~~[the provisions of]~~this section shall submit an annual report to the commissioner on or before April 1 of each year~~[following January 1, 2022]~~, that contains

the following:

1. A description of the process used to develop or select the medical necessity criteria for both***:***

a. Mental health ***or substance use disorder*** condition benefits***;*** and

b. Medical and surgical benefits;

2. Identification of all nonquantitative treatment limitations applicable to benefits and services covered under the plan that are applied to both mental health ***or substance use disorder*** condition benefits and medical and surgical benefits within each classification of benefits;

3. ***Except as provided in subparagraph 4. of this paragraph,*** the results of an analysis that demonstrates ***the insurer's and any designee's or agent's*** compliance with subsection (1)(b) and (c) of this section for the medical necessity criteria described in subparagraph 1. of this paragraph and for each nonquantitative treatment limitation identified in subparagraph 2. of this paragraph, as written and in operation. At a minimum, the results of the analysis shall:

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

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

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

      i. Used to design each nonquantitative treatment limitation, as written, and the as-written processes and strategies used to apply the nonquantitative treatment limitation to mental

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

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

d. ***Include an evaluation of standards related to:***

i. Network composition;

ii. Out-of-network utilization and reimbursement rates; and

iii. Medical management techniques, including prior authorization; and

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

4. ***If the results of any analysis performed under subparagraph 3. of this paragraph indicates a lack of compliance with subsection (1)(b) or (c) of this section:***

a. A description of the policies and processes that resulted in a lack of compliance; and

b. A remediation plan to be approved by the commissioner; and

5. Any additional information that may be prescribed by the commissioner for use in determining compliance with the requirements of this section.

(b) ***Each***~~[The]~~ annual report shall be ***submitted by the insurer:***

1. ~~[Submitted]~~In a manner and format prescribed by the commissioner through ***an*** administrative regulation ***promulgated in accordance with KRS Chapter 13A; and***

2. To the:

a. Commissioner; and

b. Legislative Research Commission, for referral on or before June 1 of each year to:

i. The Interim Joint Committee on Health Services;

ii. The Interim Joint Committee on Banking and Insurance; and

iii. Any other appropriate committees.

(3) A willful violation of this section shall constitute an act of discrimination and shall be an unfair trade practice under this chapter~~[. The remedies provided under Subtitle 12 of this chapter shall apply to conduct in violation of this section]~~.

(4) (a) Subject to paragraph (c) of this subsection, the Attorney General may enforce this section by bringing an action in the name of the Commonwealth, or on behalf of persons residing in the Commonwealth, against any person the Attorney General believes has violated, is violating, or is likely to violate this section.

(b) The Attorney General:

1. May demand, and require the production of, any information, documentary material, or evidence from any person the Attorney General believes may have violated, may be violating, or may be likely

to violate this section; and

2. Shall have all of the powers and duties provided to the Attorney General under KRS Chapter 15 to investigate and prosecute any violation or likely violation of this section.

(c) 1. Prior to bringing an action under paragraph (a) of this subsection, the Attorney General shall provide each person thirty (30) days written notice of the specific provisions of this section that the Attorney General believes the person has violated, is violating, or is likely to violate.

2. Except as provided in subparagraph 3. of this paragraph, the Attorney General shall not bring an action under paragraph (a) of this subsection against a person if, within fourteen (14) days of the date of the notice provided under subparagraph 1. of this paragraph, the person:

a. Cures the noticed violations or likely violations; and

b. Provides the Attorney General with an express written statement that:

i. Any noticed violations have been cured and any noticed likely violations will not occur; and

ii. No further violations, including any likely violations, of this section by the person will occur.

3. The Attorney General may bring an action under paragraph (a) of this subsection against any person alleged to be in:

a. Violation, or likely violation, of this section following the cure period provided to the person under this paragraph; or

b. Breach of an express written statement submitted by the person to the Attorney General under subparagraph 2.b. of this

paragraph.

(d) In any action brought under paragraph (a) of this subsection, the Attorney General may:

1. Obtain:

a. A declaratory judgment that one (1) or more alleged acts or practices by a person or persons violate this section;

b. An injunction against any person that has violated, is violating, or is likely to violate this section; and

c. Any other appropriate orders of the court to compel compliance with this section; and

2. Recover:

a. Actual damages, which shall be paid to the injured person or persons;

b. Any of the civil penalties set forth in KRS 367.990 for a violation of KRS Chapter 367 for each violation and likely violation of this section that occurs after the cure period provided under paragraph (c) of this subsection;

c. Reasonable expenses incurred in investigating and preparing the case;

d. Court costs;

e. Reasonable attorney's fees; and

f. Any other relief ordered by the court.

(5) (a) Subject to paragraph (c) of this subsection, any person, including a health facility or health professional, directly injured by a violation or likely violation of this section may bring a private cause of action against the person or persons alleged to have committed the violation or likely violation.

(b) An action brought under paragraph (a) of this subsection may be filed in

the:

1. Circuit Court of the county in which the injured person resides or conducts business; or

2. Franklin Circuit Court.

(c) Prior to bringing an action under paragraph (a) of this subsection, an injured person shall make reasonable efforts to provide notice to each person alleged to be in violation or likely violation of this section:

1. Of the person's alleged violations and likely violations of this section; and

2. That failure to cure any alleged violation or likely violation of this section within fourteen (14) days of the date of the notice may result in a civil action being filed against the person in a court of competent jurisdiction.

(d) In any action brought under paragraph (a) of this subsection, the plaintiff may:

1. Obtain:

a. A declaratory judgment that one (1) or more alleged acts or practices by a person or persons violate this section;

b. An injunction against any person that has violated, is violating, or is likely to violate this section; and

c. Any other appropriate orders of the court to compel compliance with this section; and

2. Recover necessary costs, expenses, and reasonable attorney's fees.

(6) Each occurrence of any of the following shall constitute a separate violation of, and direct injury under, this section that is subject to the remedies and penalties available under this section:

(a) A person fails to comply with any requirement of this section;

(b) The denial of a claim under a health benefit plan as a result of a violation under this section;

(c) An insured seeks but is unable to obtain mental health or substance use disorder condition benefits under a health benefit plan as a result of a violation under this section; and

(d) A health facility or health professional attempts but is unable to provide mental health or substance use disorder condition benefits under a health benefit plan as a result of a violation under this section.

(7) (a) The remedies and penalties set forth in this section shall be cumulative.

(b) This section shall not be construed to limit or restrict the powers, duties, remedies, or penalties available to the commissioner, the Attorney General, the Commonwealth, or any other person under any other statutory or common law.

(c) An action taken pursuant to this section, or order of a court to enforce an action taken pursuant to this section, shall not in any way relieve or absolve any affected person from any other liability, penalty, or forfeiture under law.

(8) The Attorney General may promulgate administrative regulations in accordance with KRS Chapter 13A that are necessary to effectuate, or as an aid to the effectuation of, the proper enforcement this section.

➔SECTION 3. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-669 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section, "health care professional" means any health care professional, including but not limited to a health care provider, that is licensed or otherwise authorized to practice in Kentucky.

(2) An insurer shall comply with KRS 304.17A-700 to 304.17A-730 with respect to any claim submitted by a health care professional for the diagnosis or treatment

of a mental health or substance use disorder condition.

(3) Notwithstanding any other law, the Attorney General may:

(a) Enforce this section in accordance with paragraph (b) of this subsection; and

(b) Take any enforcement action for a violation of this section that the commissioner or department is authorized to take for a violation of KRS 304.17A-700 to 304.17A-730, including but not limited to assessing fines under KRS 304.99-123, except the Attorney General shall not revoke, suspend, or refuse to renew an insurer's certificate of authority unless otherwise authorized by law.

➔SECTION 4. A NEW SECTION OF KRS 304.17A-660 TO 304.17A-669 IS CREATED TO READ AS FOLLOWS:

(1) There is created the Advisory Council on Mental Health and Substance Use Disorder Parity whose duties shall be to advise the Attorney General on issues relating to parity in the provision of mental health and substance use disorder condition benefits, including violations of parity laws and remedies relating thereto.

(2) (a) The advisory council shall consist of the following members:

1. The Attorney General, or the Attorney General's designee, who shall serve as:

a. A nonvoting ex officio member; and

b. Chair of the council; and

2. A representative from each of the following:

a. The Kentucky Psychiatric Medical Association;

b. The Kentucky Psychological Association;

c. The Kentucky Society for Clinical Social Work;

d. The Kentucky Association of Regional Programs;

e. The Kentucky Mental Health Coalition;

f. The National Alliance on Mental Illness Kentucky;

g. People Advocating Recovery; and

h. Build Better Health.

(b) The members described in paragraph (a)2. of this subsection:

1. Shall:

a. Be appointed by the Attorney General; and

b. Serve a two (2) year term; and

2. May be reappointed.

(3) The advisory council shall:

(a) Meet at least twice per calendar year; and

(b) Be a budgetary unit of the Department of Law, which shall:

1. Pay all of the advisory council's necessary operating expenses; and

2. Furnish all office space, personnel, equipment, supplies, and technical or administrative services required by the advisory council in the performance of the functions established in this section.

➔Section 5. KRS 304.17A-665 is amended to read as follows:

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

(2) (a) The commissioner shall annually publish the following for public distribution on the department's website:

1. Each report submitted under Section 2 of this Act; and

2. A summary of each report referenced in subparagraph 1. of this paragraph.

(b) Upon request, the commissioner shall present his or her findings regarding the compliance of insurers, including their designees and agents, with Section 2 of this Act to:

1. The Interim Joint Committee on Banking and Insurance;

2. The Interim Joint Committee on Health Services; and

3. Any other appropriate committee of the Legislative Research Commission.

➔Section 6. KRS 304.17A-669 is amended to read as follows:

(1) Nothing in KRS 304.17A-660 to 304.17A-669 shall be construed as mandating coverage for mental health ***or substance use disorder*** conditions.

(2) A group health benefit plan covering fewer than fifty-one (51) employees that is not otherwise required to provide parity in mental health ***or substance use disorder*** condition benefits under federal law shall be exempt from the provisions of KRS 304.17A-660 to 304.17A-669.

➔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 (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) ***KRS 304.17A-660 to 304.17A-669; 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. (1) For the initial appointment of the members referenced in subsection (2)(a)2. of Section 4 of this Act:

(a) Four of the appointments shall be for a one-year term; and

(b) Four of the appointments shall be for a two-year term.

(2) The first meeting of the Advisory Council on Mental Health and Substance Use Disorder Parity established under Section 4 of this Act shall be held not later than July 1, 2027.

➔Section 9. Sections 1, 2, 3 6, and 7 of this Act apply to contracts issued or renewed on or after January 1, 2027.

➔Section 10. This Act takes effect January 1, 2027.