

1 AN ACT relating to telehealth.

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

3 ➔Section 1. KRS 304.17A-138 is amended to read as follows:

4 (1) (a) A health benefit plan shall ***include coverage for services provided to an***
 5 ***insured through telehealth, as defined in Section 2 of this Act. Telehealth***
 6 ***coverage and reimbursement shall be equivalent to the coverage and***
 7 ***reimbursement for the same service provided in person***~~[not exclude a service~~
 8 ~~from coverage solely because the service is provided through telehealth and~~
 9 ~~not provided through a face-to-face consultation if the consultation is provided~~
 10 ~~through the telehealth network established under KRS 194A.125. A health~~
 11 ~~benefit plan may provide coverage for a consultation at a site not within the~~
 12 ~~telehealth network at the discretion of the insurer].~~

13 (b) ***A health benefit plan shall not:***

14 ***1. Require a provider to be physically present with a patient or client,***
 15 ***unless the provider determines that it is necessary to perform those***
 16 ***services in person;***

17 ***2. Require prior authorization, medical review, or administrative***
 18 ***clearance for telehealth that would not be required if a service were***
 19 ***provided in person;***

20 ***3. Require demonstration that it is necessary to provide services to a***
 21 ***patient or client through telehealth;***

22 ***4. Restrict or deny coverage of telehealth based solely on the***
 23 ***communication technology or application used to deliver the***
 24 ***telehealth services; or***

25 ***5. Require a provider to be part of the telehealth network or subject to***
 26 ***oversight or regulation by the Telehealth Board, established pursuant***
 27 ***to KRS 194A.125***~~[A telehealth consultation shall not be reimbursable~~

1 ~~under this section if it is provided through the use of an audio-only~~
2 ~~telephone, facsimile machine, or electronic mail].~~

3 (2) Benefits for a service provided through telehealth required by this section may be
4 made subject to a deductible, copayment, or coinsurance requirement. A deductible,
5 copayment, or coinsurance applicable to a particular service provided through
6 telehealth shall not exceed the deductible, copayment, or coinsurance required by
7 the health benefit plan for the same service provided *in person*~~[through a face-to-~~
8 ~~face consultation].~~

9 (3) **Nothing in this section shall be construed to require a health benefit plan to:**

10 **(a) Provide coverage for services that are not medically necessary; or**

11 **(b) Pay for transmission costs incurred by a patient or client during a telehealth**
12 **encounter.**

13 **(4)** Payment made under this section may be consistent with any provider network
14 arrangements that have been established for the health benefit plan.

15 **(5)**~~**(4)**~~ The department shall promulgate an administrative regulation in accordance
16 with KRS Chapter 13A to designate the claim forms and records required to be
17 maintained in conjunction with this section.

18 ➔Section 2. KRS 304.17A-005 is amended to read as follows:

19 As used in this subtitle, unless the context requires otherwise:

20 (1) "Association" means an entity, other than an employer-organized association, that
21 has been organized and is maintained in good faith for purposes other than that of
22 obtaining insurance for its members and that has a constitution and bylaws;

23 (2) "At the time of enrollment" means:

24 (a) At the time of application for an individual, an association that actively
25 markets to individual members, and an employer-organized association that
26 actively markets to individual members; and

27 (b) During the time of open enrollment or during an insured's initial or special

- 1 enrollment periods for group health insurance;
- 2 (3) "Base premium rate" means, for each class of business as to a rating period, the
3 lowest premium rate charged or that could have been charged under the rating
4 system for that class of business by the insurer to the individual or small group, or
5 employer as defined in KRS 304.17A-0954, with similar case characteristics for
6 health benefit plans with the same or similar coverage;
- 7 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,
8 or employer-organized association that limits coverage to physician, pharmacy,
9 home health, preventive, emergency, and inpatient and outpatient hospital services
10 in accordance with the requirements of this subtitle. If vision or eye services are
11 offered, these services may be provided by an ophthalmologist or optometrist.
12 Chiropractic benefits may be offered by providers licensed pursuant to KRS
13 Chapter 312;
- 14 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
15 91(d)(3);
- 16 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
- 17 (7) "COBRA" means any of the following:
- 18 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
19 vaccines;
- 20 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
21 et seq. other than sec. 1169); or
- 22 (c) 42 U.S.C. sec. 300bb;
- 23 (8) (a) "Creditable coverage" means, with respect to an individual, coverage of the
24 individual under any of the following:
- 25 1. A group health plan;
- 26 2. Health insurance coverage;
- 27 3. Part A or Part B of Title XVIII of the Social Security Act;

- 1 4. Title XIX of the Social Security Act, other than coverage consisting
- 2 solely of benefits under section 1928;
- 3 5. Chapter 55 of Title 10, United States Code, including medical and dental
- 4 care for members and certain former members of the uniformed services,
- 5 and for their dependents; for purposes of Chapter 55 of Title 10, United
- 6 States Code, "uniformed services" means the Armed Forces and the
- 7 Commissioned Corps of the National Oceanic and Atmospheric
- 8 Administration and of the Public Health Service;
- 9 6. A medical care program of the Indian Health Service or of a tribal
- 10 organization;
- 11 7. A state health benefits risk pool;
- 12 8. A health plan offered under Chapter 89 of Title 5, United States Code,
- 13 such as the Federal Employees Health Benefit Program;
- 14 9. A public health plan as established or maintained by a state, the United
- 15 States government, a foreign country, or any political subdivision of a
- 16 state, the United States government, or a foreign country that provides
- 17 health coverage to individuals who are enrolled in the plan;
- 18 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
- 19 U.S.C. sec. 2504(e)); or
- 20 11. Title XXI of the Social Security Act, such as the State Children's Health
- 21 Insurance Program.
- 22 (b) This term does not include coverage consisting solely of coverage of excepted
- 23 benefits as defined in subsection (14) of this section;
- 24 (9) "Dependent" means any individual who is or may become eligible for coverage
- 25 under the terms of an individual or group health benefit plan because of a
- 26 relationship to a participant;
- 27 (10) "Employee benefit plan" means an employee welfare benefit plan or an employee

1 pension benefit plan or a plan which is both an employee welfare benefit plan and
2 an employee pension benefit plan as defined by ERISA;

3 (11) "Eligible individual" means an individual:

4 (a) For whom, as of the date on which the individual seeks coverage, the
5 aggregate of the periods of creditable coverage is eighteen (18) or more
6 months and whose most recent prior creditable coverage was under a group
7 health plan, governmental plan, or church plan. A period of creditable
8 coverage under this paragraph shall not be counted if, after that period, there
9 was a sixty-three (63) day period of time, excluding any waiting or affiliation
10 period, during all of which the individual was not covered under any
11 creditable coverage;

12 (b) Who is not eligible for coverage under a group health plan, Part A or Part B of
13 Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a
14 state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et
15 seq.) and does not have other health insurance coverage;

16 (c) With respect to whom the most recent coverage within the coverage period
17 described in paragraph (a) of this subsection was not terminated based on a
18 factor described in KRS 304.17A-240(2)(a), (b), and (c);

19 (d) If the individual had been offered the option of continuation coverage under a
20 COBRA continuation provision or under KRS 304.18-110, who elected the
21 coverage; and

22 (e) Who, if the individual elected the continuation coverage, has exhausted the
23 continuation coverage under the provision or program;

24 (12) "Employer-organized association" means any of the following:

25 (a) Any entity that was qualified by the commissioner as an eligible association
26 prior to April 10, 1998, and that has actively marketed a health insurance
27 program to its members since September 8, 1996, and which is not insurer-

1 controlled;

2 (b) Any entity organized under KRS 247.240 to 247.370 that has actively
3 marketed health insurance to its members and that is not insurer-controlled; or

4 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-
5 91(d)(3), whose members consist principally of employers, and for which the
6 entity's health insurance decisions are made by a board or committee, the
7 majority of which are representatives of employer members of the entity who
8 obtain group health insurance coverage through the entity or through a trust or
9 other mechanism established by the entity, and whose health insurance
10 decisions are reflected in written minutes or other written documentation.

11 Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and
12 except as otherwise provided by the definition of "large group" contained in
13 subsection (30) of this section, an employer-organized association shall not be
14 treated as an association, small group, or large group under this subtitle, provided
15 that an employer-organized association that is a bona fide association as defined in
16 subsection (5) of this section shall be treated as a large group under this subtitle;

17 (13) "Employer-organized association health insurance plan" means any health insurance
18 plan, policy, or contract issued to an employer-organized association, or to a trust
19 established by one (1) or more employer-organized associations, or providing
20 coverage solely for the employees, retired employees, directors and their spouses
21 and dependents of the members of one (1) or more employer-organized
22 associations;

23 (14) "Excepted benefits" means benefits under one (1) or more, or any combination
24 thereof, of the following:

25 (a) Coverage only for accident, including accidental death and dismemberment,
26 or disability income insurance, or any combination thereof;

27 (b) Coverage issued as a supplement to liability insurance;

- 1 (c) Liability insurance, including general liability insurance and automobile
2 liability insurance;
- 3 (d) Workers' compensation or similar insurance;
- 4 (e) Automobile medical payment insurance;
- 5 (f) Credit-only insurance;
- 6 (g) Coverage for on-site medical clinics;
- 7 (h) Other similar insurance coverage, specified in administrative regulations,
8 under which benefits for medical care are secondary or incidental to other
9 insurance benefits;
- 10 (i) Limited scope dental or vision benefits;
- 11 (j) Benefits for long-term care, nursing home care, home health care, community-
12 based care, or any combination thereof;
- 13 (k) Such other similar, limited benefits as are specified in administrative
14 regulations;
- 15 (l) Coverage only for a specified disease or illness;
- 16 (m) Hospital indemnity or other fixed indemnity insurance;
- 17 (n) Benefits offered as Medicare supplemental health insurance, as defined under
18 section 1882(g)(1) of the Social Security Act;
- 19 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
20 United States Code;
- 21 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
22 supplemental to coverage under a group health plan; and
- 23 (q) Health flexible spending arrangements;
- 24 (15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
25 1002(32);
- 26 (16) "Group health plan" means a plan, including a self-insured plan, of or contributed to
27 by an employer, including a self-employed person, or employee organization, to

1 provide health care directly or otherwise to the employees, former employees, the
2 employer, or others associated or formerly associated with the employer in a
3 business relationship, or their families;

4 (17) "Guaranteed acceptance program participating insurer" means an insurer that is
5 required to or has agreed to offer health benefit plans in the individual market to
6 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
7 304.17A-480;

8 (18) "Guaranteed acceptance program plan" means a health benefit plan in the individual
9 market issued by an insurer that provides health benefits to a guaranteed acceptance
10 program qualified individual and is eligible for assessment and refunds under the
11 guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

12 (19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance
13 Program established and operated under KRS 304.17A-400 to 304.17A-480;

14 (20) "Guaranteed acceptance program qualified individual" means an individual who, on
15 or before December 31, 2000:

16 (a) Is not an eligible individual;

17 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
18 spouse or a dependent of an individual who:

19 1. Waived coverage under KRS 304.17A-210(2); or

20 2. Did not elect family coverage that was available through the association
21 or group market;

22 (c) Within the previous three (3) years has been diagnosed with or treated for a
23 high-cost condition or has had benefits paid under a health benefit plan for a
24 high-cost condition, or is a high risk individual as defined by the underwriting
25 criteria applied by an insurer under the alternative underwriting mechanism
26 established in KRS 304.17A-430(3);

27 (d) Has been a resident of Kentucky for at least twelve (12) months immediately

1 preceding the effective date of the policy; and

2 (e) Has not had his or her most recent coverage under any health benefit plan
3 terminated or nonrenewed because of any of the following:

4 1. The individual failed to pay premiums or contributions in accordance
5 with the terms of the plan or the insurer had not received timely
6 premium payments;

7 2. The individual performed an act or practice that constitutes fraud or
8 made an intentional misrepresentation of material fact under the terms of
9 the coverage; or

10 3. The individual engaged in intentional and abusive noncompliance with
11 health benefit plan provisions;

12 (21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or
13 before December 31, 2000, that is not a guaranteed acceptance plan participating
14 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
15 guaranteed acceptance plan supporting insurer shall not include an employer-
16 sponsored self-insured health benefit plan exempted by ERISA;

17 (22) "Health benefit plan" means any hospital or medical expense policy or certificate;
18 nonprofit hospital, medical-surgical, and health service corporation contract or
19 certificate; provider sponsored integrated health delivery network; a self-insured
20 plan or a plan provided by a multiple employer welfare arrangement, to the extent
21 permitted by ERISA; health maintenance organization contract; or any health
22 benefit plan that affects the rights of a Kentucky insured and bears a reasonable
23 relation to Kentucky, whether delivered or issued for delivery in Kentucky, and
24 does not include policies covering only accident, credit, dental, disability income,
25 fixed indemnity medical expense reimbursement policy, long-term care, Medicare
26 supplement, specified disease, vision care, coverage issued as a supplement to
27 liability insurance, insurance arising out of a workers' compensation or similar law,

- 1 automobile medical-payment insurance, insurance under which benefits are payable
2 with or without regard to fault and that is statutorily required to be contained in any
3 liability insurance policy or equivalent self-insurance, short-term coverage, student
4 health insurance offered by a Kentucky-licensed insurer under written contract with
5 a university or college whose students it proposes to insure, medical expense
6 reimbursement policies specifically designed to fill gaps in primary coverage,
7 coinsurance, or deductibles and provided under a separate policy, certificate, or
8 contract, or coverage supplemental to the coverage provided under Chapter 55 of
9 Title 10, United States Code, or limited health service benefit plans;
- 10 (23) "Health care provider" or "provider" means any facility or service required to be
11 licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS
12 Chapter 315, or home medical equipment and services provider as defined pursuant
13 to KRS 309.402, and any of the following independent practicing practitioners:
- 14 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;
 - 15 (b) Chiropractors licensed under KRS Chapter 312;
 - 16 (c) Dentists licensed under KRS Chapter 313;
 - 17 (d) Optometrists licensed under KRS Chapter 320;
 - 18 (e) Physician assistants regulated under KRS Chapter 311;
 - 19 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and
 - 20 (g) Other health care practitioners as determined by the department by
21 administrative regulations promulgated under KRS Chapter 13A;
- 22 (24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
23 Program, means a covered condition in an individual policy as listed in
24 paragraph (c) of this subsection or as added by the commissioner in
25 accordance with KRS 304.17A-280, but only to the extent that the condition
26 exceeds the numerical score or rating established pursuant to uniform
27 underwriting standards prescribed by the commissioner under paragraph (b) of

1 this subsection that account for the severity of the condition and the cost
2 associated with treating that condition.

3 (b) The commissioner by administrative regulation shall establish uniform
4 underwriting standards and a score or rating above which a condition is
5 considered to be high-cost by using:

- 6 1. Codes in the most recent version of the "International Classification of
7 Diseases" that correspond to the medical conditions in paragraph (c) of
8 this subsection and the costs for administering treatment for the
9 conditions represented by those codes; and
- 10 2. The most recent version of the questionnaire incorporated in a national
11 underwriting guide generally accepted in the insurance industry as
12 designated by the commissioner, the scoring scale for which shall be
13 established by the commissioner.

14 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
15 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
16 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
17 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
18 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
19 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,
20 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
21 stroke, syringomyelia, and Wilson's disease;

22 (25) "Index rate" means, for each class of business as to a rating period, the arithmetic
23 average of the applicable base premium rate and the corresponding highest premium
24 rate;

25 (26) "Individual market" means the market for the health insurance coverage offered to
26 individuals other than in connection with a group health plan. The individual market
27 includes an association plan that is not employer related, issued to individuals on an

1 individually underwritten basis, other than an employer-organized association or a
2 bona fide association, that has been organized and is maintained in good faith for
3 purposes other than obtaining insurance for its members and that has a constitution
4 and bylaws;

5 (27) "Insurer" means any insurance company; health maintenance organization; self-
6 insurer or multiple employer welfare arrangement not exempt from state regulation
7 by ERISA; provider-sponsored integrated health delivery network; self-insured
8 employer-organized association, or nonprofit hospital, medical-surgical, dental, or
9 health service corporation authorized to transact health insurance business in
10 Kentucky;

11 (28) "Insurer-controlled" means that the commissioner has found, in an administrative
12 hearing called specifically for that purpose, that an insurer has or had a substantial
13 involvement in the organization or day-to-day operation of the entity for the
14 principal purpose of creating a device, arrangement, or scheme by which the insurer
15 segments employer groups according to their actual or anticipated health status or
16 actual or projected health insurance premiums;

17 (29) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

18 (30) "Large group" means:

- 19 (a) An employer with fifty-one (51) or more employees;
20 (b) An affiliated group with fifty-one (51) or more eligible members; or
21 (c) An employer-organized association that is a bona fide association as defined
22 in subsection (5) of this section;

23 (31) "Managed care" means systems or techniques generally used by third-party payors
24 or their agents to affect access to and control payment for health care services and
25 that integrate the financing and delivery of appropriate health care services to
26 covered persons by arrangements with participating providers who are selected to
27 participate on the basis of explicit standards for furnishing a comprehensive set of

1 health care services and financial incentives for covered persons using the
2 participating providers and procedures provided for in the plan;

3 (32) "Market segment" means the portion of the market covering one (1) of the
4 following:

5 (a) Individual;

6 (b) Small group;

7 (c) Large group; or

8 (d) Association;

9 (33) "Participant" means any employee or former employee of an employer, or any
10 member or former member of an employee organization, who is or may become
11 eligible to receive a benefit of any type from an employee benefit plan which covers
12 employees of the employer or members of the organization, or whose beneficiaries
13 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

14 (34) "Preventive services" means medical services for the early detection of disease that
15 are associated with substantial reduction in morbidity and mortality;

16 (35) "Provider network" means an affiliated group of varied health care providers that is
17 established to provide a continuum of health care services to individuals;

18 (36) "Provider-sponsored integrated health delivery network" means any provider-
19 sponsored integrated health delivery network created and qualified under KRS
20 304.17A-300 and KRS 304.17A-310;

21 (37) "Purchaser" means an individual, organization, employer, association, or the
22 Commonwealth that makes health benefit purchasing decisions on behalf of a group
23 of individuals;

24 (38) "Rating period" means the calendar period for which premium rates are in effect. A
25 rating period shall not be required to be a calendar year;

26 (39) "Restricted provider network" means a health benefit plan that conditions the
27 payment of benefits, in whole or in part, on the use of the providers that have

1 entered into a contractual arrangement with the insurer to provide health care
2 services to covered individuals;

3 (40) "Self-insured plan" means a group health insurance plan in which the sponsoring
4 organization assumes the financial risk of paying for covered services provided to
5 its enrollees;

6 (41) "Small employer" means, in connection with a group health plan with respect to a
7 calendar year and a plan year, an employer who employed an average of at least two
8 (2) but not more than fifty (50) employees on business days during the preceding
9 calendar year and who employs at least two (2) employees on the first day of the
10 plan year;

11 (42) "Small group" means:

12 (a) A small employer with two (2) to fifty (50) employees; or

13 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

14 (43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and

15 (44) "Telehealth" **means the delivery of health services from a provider of health care**
16 **to a patient or client at a different location through the use of information and**
17 **audio-visual communication technology, not including standard telephone,**
18 **facsimile, or electronic mail, and:**

19 **(a) Is used to deliver services to a patient or client who, within the two (2)**
20 **previous years, has established a clinical relationship with the health care**
21 **provider through an in-office or in-person visit and who maintains ongoing**
22 **communication with the health care provider as part of a continued care**
23 **relationship;**

24 **(b) Is delivered via a secure connection that complies with the requirements of**
25 **the federal Health Insurance Portability and Accountability Act of 1996,**
26 **Pub. L. No. 104-191; and**

27 **(c) Shall not require the patient or client to have secure real-time video or**

1 audio technology unless deemed clinically appropriate for the
2 circumstances by the health care provider~~[has the meaning provided in KRS~~
3 311.550].

4 ➔Section 3. KRS 18A.225 is amended to read as follows:

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

- 6 1. Any person, including an elected public official, who is regularly
7 employed by any department, office, board, agency, or branch of state
8 government; or by a public postsecondary educational institution; or by
9 any city, urban-county, charter county, county, or consolidated local
10 government, whose legislative body has opted to participate in the state-
11 sponsored health insurance program pursuant to KRS 79.080; and who
12 is either a contributing member to any one (1) of the retirement systems
13 administered by the state, including but not limited to the Kentucky
14 Retirement Systems, Kentucky Teachers' Retirement System, the
15 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is
16 receiving a contractual contribution from the state toward a retirement
17 plan; or, in the case of a public postsecondary education institution, is an
18 individual participating in an optional retirement plan authorized by
19 KRS 161.567;
- 20 2. Any certified or classified employee of a local board of education;
- 21 3. Any elected member of a local board of education;
- 22 4. Any person who is a present or future recipient of a retirement
23 allowance from the Kentucky Retirement Systems, Kentucky Teachers'
24 Retirement System, the Legislators' Retirement Plan, the Judicial
25 Retirement Plan, or the Kentucky Community and Technical College
26 System's optional retirement plan authorized by KRS 161.567, except
27 that a person who is receiving a retirement allowance and who is age

- 1 sixty-five (65) or older shall not be included, with the exception of
2 persons covered under KRS 61.702(4)(c), unless he or she is actively
3 employed pursuant to subparagraph 1. of this paragraph; and
- 4 5. Any eligible dependents and beneficiaries of participating employees
5 and retirees who are entitled to participate in the state-sponsored health
6 insurance program;
- 7 (b) The term "health benefit plan" for the purposes of this section means a health
8 benefit plan as defined in KRS 304.17A-005;
- 9 (c) The term "insurer" for the purposes of this section means an insurer as defined
10 in KRS 304.17A-005; and
- 11 (d) The term "managed care plan" for the purposes of this section means a
12 managed care plan as defined in KRS 304.17A-500.
- 13 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
14 recommendation of the secretary of the Personnel Cabinet, shall procure, in
15 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
16 from one (1) or more insurers authorized to do business in this state, a group
17 health benefit plan that may include but not be limited to health maintenance
18 organization (HMO), preferred provider organization (PPO), point of service
19 (POS), and exclusive provider organization (EPO) benefit plans encompassing
20 all or any class or classes of employees. With the exception of employers
21 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
22 employers of any class of employees or former employees shall enter into a
23 contract with the Personnel Cabinet prior to including that group in the state
24 health insurance group. The contracts shall include but not be limited to
25 designating the entity responsible for filing any federal forms, adoption of
26 policies required for proper plan administration, acceptance of the contractual
27 provisions with health insurance carriers or third-party administrators, and

1 adoption of the payment and reimbursement methods necessary for efficient
2 administration of the health insurance program. Health insurance coverage
3 provided to state employees under this section shall, at a minimum, contain
4 the same benefits as provided under Kentucky Kare Standard as of January 1,
5 1994, and shall include a mail-order drug option as provided in subsection
6 (13) of this section. All employees and other persons for whom the health care
7 coverage is provided or made available shall annually be given an option to
8 elect health care coverage through a self-funded plan offered by the
9 Commonwealth or, if a self-funded plan is not available, from a list of
10 coverage options determined by the competitive bid process under the
11 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
12 during annual open enrollment.

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

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

24 (d) Any carrier bidding to offer health care coverage to employees shall agree to
25 provide enrollment, claims, and utilization data to the Commonwealth in a
26 format specified by the Personnel Cabinet with the understanding that the data
27 shall be owned by the Commonwealth; to provide data in an electronic form

1 and within a time frame specified by the Personnel Cabinet; and to be subject
2 to penalties for noncompliance with data reporting requirements as specified
3 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions
4 to protect the confidentiality of each individual employee; however,
5 confidentiality assertions shall not relieve a carrier from the requirement of
6 providing stipulated data to the Commonwealth.

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

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

1 employee health insurance program.

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

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

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

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

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

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

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

27 (5) No payment of premium by any department, board, agency, public postsecondary

1 educational institution, or branch of state, city, urban-county, charter county,
2 county, or consolidated local government shall constitute compensation to an
3 insured employee for the purposes of any statute fixing or limiting the
4 compensation of such an employee. Any premium or other expense incurred by any
5 department, board, agency, public postsecondary educational institution, or branch
6 of state, city, urban-county, charter county, county, or consolidated local
7 government shall be considered a proper cost of administration.

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

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

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

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

1 by the Kentucky Education Association, two (2) members from a list of five (5)
2 names submitted by the largest state employee organization of nonschool state
3 employees, two (2) members from a list of five (5) names submitted by the
4 Kentucky Association of Counties, two (2) members from a list of five (5) names
5 submitted by the Kentucky League of Cities, and two (2) members from a list of
6 names consisting of five (5) names submitted by each state employee organization
7 that has two thousand (2,000) or more members on state payroll deduction. The
8 advisory committee shall be appointed in January of each year and shall meet
9 quarterly.

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

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

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

27 (13) (a) The policies of health insurance coverage procured under subsection (2) of

1 this section shall include a mail-order drug option for maintenance drugs for
2 state employees. Maintenance drugs may be dispensed by mail order in
3 accordance with Kentucky law.

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

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

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

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

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

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

1 where the plan selected is located.

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

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

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

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

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

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

27 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the

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

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

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

14 (22) Any fully insured health benefit plan or self-insured plan issued or renewed on or
15 after July 12, 2006, to public employees pursuant to this section shall comply with
16 the provisions of KRS 304.17A-270 and 304.17A-525.

17 (23) Any ~~fully~~ insured health benefit plan or self insured plan issued or renewed on
18 or after July 12, 2006, to public employees shall comply with KRS 304.17A-600 to
19 304.17A-633 pertaining to utilization review, KRS 205.593 and 304.17A-700 to
20 304.17A-730 pertaining to payment of claims, KRS 304.14-135 pertaining to
21 uniform health insurance claim forms, KRS 304.17A-580 and 304.17A-641
22 pertaining to emergency medical care, KRS 304.99-123, and any administrative
23 regulations promulgated thereunder.

24 **(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or**
25 **after July 1, 2017, to public employees pursuant to this section shall comply with**
26 **Section 1 of this Act.**