AN ACT relating to consumer protections in health insurance.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) For purposes of this section:

(a) "Essential health benefits" means, with respect to any health benefit plan, coverage that provides the benefits that are determined by the commissioner in accordance with subsection (3) of this section;

(b) "Pre-existing condition exclusion":

1. Means a limitation or exclusion of benefits, including a denial of coverage, based on the fact that a condition was present before the effective date of coverage, or if coverage is denied, the date of denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; and

2. Includes any limitation or exclusion of benefits applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, the date of denial; and

(c) "Reviser of statutes" means the person appointed under KRS 7.140.

(2) (a) An insurer that offers health benefit plan coverage in any market, including the small group, large group, association, employer-organized association, or individual market, shall:

1. Not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status;

b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including conditions arising out of acts of domestic violence;

h. Disability;

i. Sex and gender; or

j. Any other health status-related factor that is determined appropriate by the commissioner;

2. Not require any individual, as a condition of enrollment or continued enrollment under the plan, to pay a premium or contribution which is greater than the premium or contribution, or be subject to benefits coverage that is different than the benefits coverage, for a similarly situated individual enrolled in the plan on the basis of any health status-related factor identified in subparagraph 1. of this paragraph in relation to the individual or a dependent of the individual;

3. Not impose any pre-existing condition exclusion with respect to such plan or coverage;

4. Provide coverage for essential health benefits with respect to such plan or coverage;

5. Not establish lifetime or annual limits on the dollar value of essential health benefits for any insured covered under the plan; and

6. For plans that provide dependent coverage of children, continue to make such coverage available for an adult child until the child turns twenty-six (26) years of age.

(b) An insurer that offers group health benefit plan coverage shall not adjust premium or contribution amounts for the group covered under the plan on the basis of genetic information.

(3) (a) The commissioner, by administrative regulation, shall define essential health benefits.

(b) Essential health benefits shall include at least the following general categories and the items and services covered within the categories:

1. Ambulatory patient services;

2. Emergency services;

3. Hospitalization;

4. Maternity and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;

8. Laboratory services;

9. Preventive and wellness services and chronic disease management; and

10. Pediatric services, including oral and vision care.

(c) In defining essential health benefits under this subsection, the commissioner shall ensure that the benefits are at least as comprehensive as the benefits required of plans subject to the essential health benefits requirements of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, as in effect on January 1, 2021, and any federal rules and regulations adopted thereunder, as in effect on January 1, 2021.

(4) In the case of a conflict between this section and any other law, this section shall control unless application of this section results in a reduction in coverage for any insured.

(5) (a) Any health plan or health plan sponsor not otherwise required to comply with this section may elect to comply with the provisions of this section.

(b) A health plan or health plan sponsor making an election under this subsection shall provide written notice to the commissioner, in the form and manner prescribed by the commissioner.

(6) (a) For purposes of subsection (7) of this section, the date of applicability shall be the date determined under paragraph (c) of this subsection.

(b) If any of the following laws, as in effect on January 1, 2021, are repealed, amended so as to result in a reduction in consumer protections or coverage, or ruled by a court of competent jurisdiction to be no longer enforceable in Kentucky, the commissioner shall, within thirty (30) days of the first event to occur, deliver written notification of that event and the effective date of the event to the reviser of statutes:

1. 42 U.S.C. sec. 300gg-4, relating to:

a. Eligibility rules based on health status-related factors;

b. Premiums or contributions on the basis of any health status-related factor; or

c. The adjustment of insurance premium or contribution amounts for groups on the basis of genetic information;

2. 42 U.S.C. sec. 300gg-3, and any provision of 42 U.S.C. secs. 300gg to 300gg-63, 42 U.S.C. sec. 300gg-91, 42 U.S.C. sec. 300gg-92, or 42 U.S.C. sec. 18011, relating to pre-existing condition exclusions;

3. 42 U.S.C. sec. 300gg-11, relating to lifetime and annual limits on the dollar value of benefits;

4. 42 U.S.C. sec. 300gg-14, relating to dependent coverage; or

5. 42 U.S.C. sec. 18022, relating to essential health benefit requirements.

(c) The date of applicability shall be ten (10) days after the notification under paragraph (b) of this subsection is received by the reviser of statutes, who shall, on or before the date of applicability, note the date of receipt of such notification in the official, electronic, and certified versions of the Kentucky Revised Statutes.

(d) For purposes of paragraph (b) of this subsection, the effective date of the event shall be as follows:

1. The effective date of any repeal or amendment shall be the effective date of the repealing or amending legislation; and

2. The effective date of any court ruling shall be the date upon which all appeals of that ruling have been exhausted or the time for appeal has elapsed.

(7) This section shall apply to:

(a) All health benefit plans issued or renewed on or after the date determined under subsection (6)(c) of this section; and

(b) Any health plans or health plan sponsors that elect, pursuant to subsection (5) of this section, to comply with the provisions of this section on or after the date determined under subsection (6)(c) of this section.

(8) The commissioner shall promulgate administrative regulations necessary to carry out the provisions of this section.

➔Section 2. KRS 304.17A-096 is amended to read as follows:

(1) An insurer authorized to engage in the business of insurance in the Commonwealth of Kentucky may offer one (1) or more basic health benefit plans in the individual, small group, and employer-organized association markets. A basic health benefit plan shall cover physician, pharmacy, home health, preventive, emergency, and

inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are offered, these services may be provided by an ophthalmologist or optometrist.

(2) An insurer that offers a basic health benefit plan shall be required to offer health benefit plans as defined in KRS 304.17A-005~~[(22)]~~.

(3) An insurer in the individual, small group, or employer-organized association markets that offers a basic health benefit plan may offer a basic health benefit plan that excludes from coverage any state-mandated health insurance benefit, except that the basic health benefit plan shall include coverage for diabetes as provided in KRS 304.17A-148, hospice as provided in KRS 304.17A-250(6), chiropractic benefits as provided in KRS 304.17A-171, mammograms as provided in KRS 304.17A-133, and those mandated benefits specified under federal law.

(4) Notwithstanding any other provisions of this section, mandated benefits excluded from coverage shall not be deemed to include the payment, indemnity, or reimbursement of specified health care providers for specific health care services.

(5) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 3. KRS 304.17A-097 is amended to read as follows:

An insurer that offers a basic health benefit plan shall disclose to all individuals, small employer groups and employer-organized associations prior to the issuance of a policy that the basic health benefit plan:

(1) Provides limited coverage;

(2) Includes federally mandated benefits; and

(3) Excludes state-mandated benefits, except for***:***

(a) Diabetes ***benefits*** as provided in KRS 304.17A-148***;*** ~~[,]~~

(b) Hospice ***benefits*** as provided in KRS 304.17A-250(6)***;*** ~~[, and]~~

(c) Chiropractic benefits as provided in KRS 304.17A-171***; and***

(d) Those benefits required under Section 1 of this Act.

➔Section 4. KRS 304.17A-200 is amended to read as follows:

(1) An insurer that offers health benefit plan coverage in the small group, large group, or association market may not establish rules for eligibility of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or the dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; and

(h) Disability.

(2) An insurer that offers health benefit plan coverage in the small group, large group, or association market shall not require any individual to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or a dependent of the individual. Nothing in this subsection shall prevent the insurer from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) Subject to subsections (4) to (7) of this section, each insurer that offers health benefit plan coverage in the small groups market shall accept every small employer that applies for coverage and shall accept for enrollment under this coverage every individual eligible for the coverage who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group

health benefit plan.

(a) Notwithstanding any other provision of this subsection, the insurer may establish group participation rules requiring a minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of those eligible for enrollment.

(b) The terms and participation rules of the group health benefit plan shall be uniformly applicable to small employers in the small group market.

(c) This subsection shall not apply to health benefit plan coverage offered by an insurer if the coverage is made available in the small group market only through one (1) or more bona fide associations.

(4) In the case of an insurer that offers health benefit plan coverage in the small group market through a network plan, the insurer may:

(a) Limit the employers that may apply for coverage to those with individuals who live, work, or reside in the service area of the network plan; and

(b) Within the service area of the network plan, deny coverage to employers if the insurer has demonstrated to the commissioner that:

1. The network plan will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

2. The insurer is applying this denial uniformly to all employers.

(5) An insurer, upon denying health benefit plan coverage in any service area in accordance with subsection (4) of this section, shall not offer coverage in the small group market within the service area for a period of one hundred eighty (180) days after the date the coverage is denied.

(6) An insurer may deny health benefit plan coverage in the small group market if the insurer has demonstrated to the commissioner that:

(a) The insurer does not have the financial reserves necessary to underwrite

additional coverage; and

(b) The insurer is applying this denial uniformly to all employers in the small group market.

(7) An insurer, upon denying health benefit plan coverage in connection with group health plans in accordance with subsection (6) of this section, shall not offer coverage in the small group market for a period of one hundred eighty (180) days after the date the coverage is denied or until the insurer has demonstrated to the commissioner that the insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

(8) A health benefit plan issued as an individual policy to individual employees or their dependents through or with the permission of a small employer shall be issued on a guaranteed-issue basis to all full-time employees and shall comply with the pre-existing condition provisions of KRS 304.17A-220.

(9) (a) In connection with the offering of any health benefit plan to a small employer, an insurer:

1. Shall make a reasonable disclosure to a small employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this subsection; and

2. Upon request of a small employer, provide the information described in paragraph (b) of this subsection.

(b) Subject to paragraph (c) of this subsection, with respect to an insurer offering a health benefit plan to a small employer, information described in this subsection is information concerning:

1. The provisions of the coverage concerning the insurer's right to change premium rates and the factors that may affect changes in premium rates;

2. The provisions of the health benefit plan relating to renewability of coverage;

3. The provisions of the health benefit plan relating to any preexisting condition exclusion; and

4. The benefits and premiums available under all health benefit plans for which the small employer is qualified.

(c) Information described in paragraph (b) of this subsection shall be provided to a small employer in a manner determined to be understandable by the average small employer and shall be sufficient to reasonably inform a small employer of his or her rights and obligations under the health benefit plan.

(d) An insurer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

(10) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 5. KRS 304.17A-220 is amended to read as follows:

(1) ***Except as otherwise required under Section 1 of this Act,*** all group health plans and insurers offering group health insurance coverage in the Commonwealth shall comply with the provisions of this section.

(2) Subject to subsection (8) of this section, a group health plan, and a health insurance insurer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a pre-existing condition exclusion only if:

(a) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the enrollment date. For purposes of this paragraph:

1. Medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law; and

2. The six (6) month period ending on the enrollment date begins on the

six (6) month anniversary date preceding the enrollment date;

(b) The exclusion extends for a period of not more than twelve (12) months, or eighteen (18) months in the case of a late enrollee, after the enrollment date;

(c) 1. The period of any pre-existing condition exclusion that would otherwise apply to an individual is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under subsection (3) of this section; and

2. Except for ineligible individuals who apply for coverage in the individual market, the period of any pre-existing condition exclusion that would otherwise apply to an individual may be reduced by the number of days of creditable coverage the individual has as of the effective date of coverage under the policy; and

(d) A written notice of the pre-existing condition exclusion is provided to participants under the plan, and the insurer cannot impose a pre-existing condition exclusion with respect to a participant or a dependent of the participant until such notice is provided.

(3) In reducing the pre-existing condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one (1) or more types of creditable coverage. For purposes of counting creditable coverage:

(a) If on a particular day the individual has creditable coverage from more than one (1) source, all the creditable coverage on that day is counted as one (1) day;

(b) Any days in a waiting period for coverage are not creditable coverage;

(c) Days of creditable coverage that occur before a significant break in coverage are not required to be counted; and

(d) Days in a waiting period and days in an affiliation period are not taken into

account in determining whether a significant break in coverage has occurred.

(4) An insurer may determine the amount of creditable coverage in another manner than established in subsection (3) of this section that is at least as favorable to the individual as the method established in subsection (3) of this section.

(5) If an insurer receives creditable coverage information, the insurer shall make a determination regarding the amount of the individual's creditable coverage and the length of any pre-existing exclusion period that remains. A written notice of the length of the pre-existing condition exclusion period that remains after offsetting for prior creditable coverage shall be issued by the insurer. An insurer may not impose any limit on the amount of time that an individual has to present a certificate or evidence of creditable coverage.

(6) For purposes of this section:

(a) "Pre-existing condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A pre-existing condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a health benefit plan;

(b) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the first day of coverage or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the employer changes its group health insurer, the individual's enrollment date does not change;

(c) "First day of coverage" means, in the case of an individual covered for

benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract;

(d) "Late enrollee" means an individual whose enrollment in a plan is a late enrollment;

(e) "Late enrollment" means enrollment of an individual under a group health plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

2. Through special enrollment;

(f) "Significant break in coverage" means a period of sixty-three (63) consecutive days during each of which an individual does not have any creditable coverage; and

(g) "Waiting period" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on:

1. If the application results in coverage, the date coverage begins; or

2. If the application does not result in coverage, the date on which the application is denied by the insurer or the date on which the offer of coverage lapses.

(7) (a) 1. Except as otherwise provided under subsection (3) of this section, for purposes of applying subsection (2)(c) of this section, a group health plan, and a health insurance insurer offering group health insurance

coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

2. A group health plan, or a health insurance insurer offering group health insurance coverage, may elect to apply subsection (2)(c) of this section based on coverage of benefits within each of several classes or categories of benefits specified in federal regulations. This election shall be made on a uniform basis for all participants and beneficiaries. Under this election, a group health plan or insurer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within this class or category.

3. In the case of an election with respect to a group health plan under subparagraph 2. of this paragraph, whether or not health insurance coverage is provided in connection with the plan, the plan shall:

a. Prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made this election; and

b. Include in these statements a description of the effect of this election.

(b) Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (9) of this section or in such other manner as may be specified in administrative regulations.

(8) (a) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who, within thirty (30) days after birth, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after

birth and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child.

(b) Subject to paragraph (e) of this subsection, a group health plan, and a health insurance insurer offering group health insurance coverage, may not impose any pre-existing condition exclusion on a child who is adopted or placed for adoption before attaining eighteen (18) years of age and who, within thirty (30) days after the adoption or placement for adoption, is covered under any creditable coverage. If a child is enrolled in a group health plan or other creditable coverage within thirty (30) days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage, the other group health plan may not impose any pre-existing condition exclusion on the child. This shall not apply to coverage before the date of the adoption or placement for adoption.

(c) A group health plan may not impose any pre-existing condition exclusion relating to pregnancy.

(d) A group health plan may not impose a pre-existing condition exclusion relating to a condition based solely on genetic information. If an individual is diagnosed with a condition, even if the condition relates to genetic information, the insurer may impose a pre-existing condition exclusion with respect to the condition, subject to other requirements of this section.

(e) Paragraphs (a) and (b) of this subsection shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any creditable coverage.

(9) (a) 1. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide a certificate of creditable coverage as described in subparagraph 2. of this subsection. A certificate of

creditable coverage shall be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the following events:

a. At the time an individual ceases to be covered under a health benefit plan or otherwise becomes eligible under a COBRA continuation provision;

b. In the case of an individual becoming covered under a COBRA continuation provision, at the time the individual ceases to be covered under the COBRA continuation provision; and

c. On request on behalf of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subdivision a. or b. of this subparagraph, whichever is later.

The certificate of creditable coverage as described under subdivision a. of this subparagraph may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

2. The certification described in this subparagraph is a written certification of:

a. The period of creditable coverage of the individual under the health benefit plan and the coverage, if any, under the COBRA continuation provision; and

b. The waiting period, if any, and affiliation period, if applicable, imposed with respect to the individual for any coverage under the plan.

3. To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the

certification requirement under this paragraph if the health insurance insurer offering the coverage provides for the certification in accordance with this paragraph.

(b) In the case of an election described in subsection (7)(a)2. of this section by a group health plan or health insurance insurer, if the plan or insurer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (a) of this subsection:

1. Upon request of that plan or insurer, the entity that issued the certification provided by the individual shall promptly disclose to the requesting plan or insurer information on coverage of classes and categories of health benefits available under the entity's plan or coverage; and

2. The entity may charge the requesting plan or insurer for the reasonable cost of disclosing this information.

(10) (a) A group health plan, and a health insurance insurer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible but not enrolled for coverage under the terms of the plan, or a dependent of that employee if the dependent is eligible but not enrolled for coverage under these terms, to enroll for coverage under the terms of the plan if each of the following conditions is met:

1. The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee stated in writing at that time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required

that statement at that time and provided the employee with notice of the requirement, and the consequences of the requirement, at that time;

3. The employee's or dependent's coverage described in subparagraph 1. of this paragraph:

   a. Was under a COBRA continuation provision and the coverage under that provision was exhausted; or

   b. Was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage, including as a result of legal separation, divorce, cessation of dependent status, such as obtaining the maximum age to be eligible as a dependent child, death of the employee, termination of employment, reduction in the number of hours of employment, employer contributions toward the coverage were terminated, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, or a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual; or

   c. Was offered through a health maintenance organization or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area and, loss of coverage in the group market occurred because an individual no longer resides, lives, or works in the service area, whether or not within the choice of the individual, and no other benefit package is available to the individual; and

4. An insurer shall allow an employee and dependent a period of at least thirty (30) days after an event described in this paragraph has occurred to request enrollment for the employee or the employee's dependent.

Coverage shall begin no later than the first day of the first calendar month beginning after the date the insurer receives the request for special enrollment.

(b) A dependent of a current employee, including the employee's spouse, and the employee each are eligible for enrollment in the group health plan subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee if the requirements of paragraph (a) of this subsection are satisfied.

(c) 1. If:

a. A group health plan makes coverage available with respect to a dependent of an individual;

b. The individual is a participant under the plan, or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period; and

c. A person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption;

the group health plan shall provide for a dependent special enrollment period described in subparagraph 2. of this paragraph during which the person or, if not otherwise enrolled, the individual, may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

2. A dependent special enrollment period under this subparagraph shall be a period of at least thirty (30) days and shall begin on the later of:

a. The date dependent coverage is made available; or

b. The date of the marriage, birth, or adoption or placement for

adoption, as the case may be, described in subparagraph 1.c. of this paragraph.

3. If an individual seeks to enroll a dependent during the first thirty (30) days of the dependent special enrollment period, the coverage of the dependent shall become effective:

a. In the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

b. In the case of a dependent's birth, as of the date of the birth; or

c. In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the employer shall provide the employee with a notice of special enrollment rights.

(11) (a) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

1. No pre-existing condition exclusion is imposed with respect to coverage through the organization;

2. The period is applied uniformly without regard to any health status-related factors; and

3. The period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

(b) 1. For purposes of this section, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health

insurance coverage becomes effective. The organization is not required to provide health care services or benefits during this period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

2. This period shall begin on the enrollment date.

3. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(c) A health maintenance organization described in paragraph (a) of this subsection may use alternative methods other than those described in that paragraph to address adverse selection as approved by the commissioner.

➔Section 6. KRS 304.17A-230 is amended to read as follows:

(1) A health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth shall not impose any pre-existing conditions exclusions as to any eligible individual.

(2) Each health insurer offering individual health benefit plan coverage in the individual market in the Commonwealth that chooses to impose a pre-existing conditions exclusion on individuals who do not meet the definition of eligible individual shall comply with the provisions of KRS 304.17A-220, which establishes standards and requirements for pre-existing conditions exclusions for group health plans, including crediting previous coverage, and certification of coverage. Pregnancy may be considered to be a pre-existing condition.

(3) Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the information.

(4) The ***commissioner*** ~~[Department of Insurance]~~ shall promulgate administrative regulations necessary to carry out the provisions of this section and KRS 304.17A-220.

(5) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 7. KRS 304.17A-250 is amended to read as follows:

(1) The commissioner shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan. After July 15, 2004, insurers may offer the standard health benefit plan in the individual or small group markets. Except as may be necessary to coordinate with changes in federal law, the commissioner shall not alter, amend, or replace the standard health benefit plan more frequently than annually.

(2) If offered, the standard health benefit plan may be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of KRS 304.17B-021 for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who offers the standard health benefit plan may offer the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) ***Except as provided in subsection (13) of this section,*** nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue,

renewability, or pre-existing condition exclusion rights or provisions that are more generous to the applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6) All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(7) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the commissioner as provided in KRS 304.18-085.

(8) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(9) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(10) Any health insurer that fails to issue a premium rate quote to an individual within

thirty (30) days of receiving a properly completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(11) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(12) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

(13) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 8. KRS 304.17A-256 is amended to read as follows:

(1) All group health benefit plans which provide dependent benefits shall offer the master policyholder the following two (2) options to purchase coverage for an

unmarried dependent child:

(a) Coverage until age nineteen (19) and coverage to unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support; and

(b) Coverage until age twenty-five (25).

(2) The offer of coverage under paragraph (b) of subsection (1) of this section shall include a disclaimer that selecting either option may have tax implications.

(3) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 9. KRS 304.17A-430 is amended to read as follows:

(1) A health benefit plan shall be considered a program plan and is eligible for inclusion in calculating assessments and refunds under the program risk adjustment process if it meets all of the following criteria:

(a) The health benefit plan was purchased by an individual to provide benefits for only one (1) or more of the following: the individual, the individual's spouse, or the individual's children. Health insurance coverage provided to an individual in the group market or otherwise in connection with a group health plan does not satisfy this criteria even if the individual, or the individual's spouse or parent, pays some or all of the cost of the coverage unless the coverage is offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;

(b) An individual entitled to benefits under the health benefit plan has been diagnosed with a high-cost condition on or before the effective date of the individual's coverage for coverage issued on a guarantee-issue basis after July 15, 1995;

(c) The health benefit plan imposes the maximum pre-existing condition exclusion permitted under KRS 304.17A-200;

(d) The individual purchasing the health benefit plan is not eligible for or covered by other coverage; and

(e) The individual is not a state employee eligible for or covered by the state employee health insurance plan under KRS Chapter 18A.

(2) Notwithstanding the provisions of subsection (1) of this section, if the total claims paid for the high-cost condition under a program plan for any three (3) consecutive years are less than the premiums paid under the program plan for those three (3) consecutive years, then the following shall occur:

(a) The policy shall not be considered to be a program plan thereafter until the first renewal of the policy after there are three (3) consecutive years in which the total claims paid under the policy have exceeded the total premiums paid for the policy and at the time of the renewal the policy also qualifies under subsection (1) as a program plan; and

(b) Within the last six (6) months of the third year, the insurer shall provide each person entitled to benefits under the policy who has a high-cost condition with a written notice of insurability. The notice shall state that the recipient may be able to purchase a health benefit plan other than a program plan and shall also state that neither the notice nor the individual's actions to purchase a health benefit plan other than a program plan shall affect the individual's eligibility for plan coverage. The notice shall be valid for six (6) months.

(3) (a) There is established within the guaranteed acceptance program the alternative underwriting mechanism that a participating insurer may elect to use. An insurer that elects this mechanism shall use the underwriting criteria that the insurer has used for the past twelve (12) months for purposes of the program plan requirement in paragraph (b) of subsection (1) of this section for high-risk individuals rather than using the criteria established in KRS 304.17A-005 and 304.17A-280 for high-cost conditions.

(b) An insurer that elects to use the alternative underwriting mechanism shall make written application to the commissioner. Before the insurer may implement the mechanism, the insurer shall obtain approval of the commissioner. Annually thereafter, the insurer shall obtain the commissioner's approval of the underwriting criteria of the insurer before the insurer may continue to use the alternative underwriting mechanism.

(4) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 10. KRS 304.17-310 is amended to read as follows:

(1) Family expense health insurance is that provided under a policy issued to one (1) of the family members insured, who shall be deemed the policyholder, covering any two (2) or more eligible members of a family, including husband, wife, unmarried dependent children, to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support, and any other person dependent upon the policyholder. Any authorized health insurer may issue the insurance.

(2) An individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state more than 120 days after June 13, 1968, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of an intellectual or physical disability and (b) chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer or corporation by the policyholder or subscriber within thirty-one (31) days of the child's attainment of the limiting age

and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(3) Insurers offering family expense health insurance shall offer the applicant the option to purchase coverage for unmarried dependent children until age twenty-five (25).

(4) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 11. KRS 304.17B-015 is amended to read as follows:

(1) Any individual who is an eligible individual and a resident of Kentucky is eligible for coverage under Kentucky Access, except as specified in paragraphs (a), (b), (d), and (e) of subsection (4) of this section.

(2) Any individual who is not an eligible individual who has been a resident of the Commonwealth for at least twelve (12) months immediately preceding the application for Kentucky Access coverage is eligible for coverage under Kentucky Access if one (1) of the following conditions is met:

(a) The individual has been rejected by at least one (1) insurer for coverage of a health benefit plan that is substantially similar to Kentucky Access coverage;

(b) The individual has been offered coverage substantially similar to Kentucky Access coverage at a premium rate greater than the Kentucky Access premium rate at the time of enrollment or upon renewal; or

(c) The individual has a high-cost condition listed in KRS 304.17B-001.

(3) A Kentucky Access enrollee whose premium rates exceed claims for a three (3) year period shall be issued a notice of insurability. The notice shall indicate that the Kentucky Access enrollee has not had claims exceed premium rates for a three (3) year period and may be used by the enrollee to obtain insurance in the regular individual market.

(4) An individual shall not be eligible for coverage under Kentucky Access if:

(a) 1. The individual has, or is eligible for, on the effective date of coverage

under Kentucky Access, substantially similar coverage under another contract or policy, unless the individual was issued coverage from a GAP participating insurer as a GAP qualified individual prior to January 1, 2001. A GAP qualified individual shall be automatically eligible for coverage under Kentucky Access without regard to the requirements of subsection (2) of this section; or

2. For individuals meeting the requirements of KRS 304.17A-005(11), the individual has, or is eligible for, on the effective date of coverage under Kentucky Access, coverage under a group health plan.

An individual who is ineligible for coverage pursuant to this paragraph shall not preclude the individual's spouse or dependents from being eligible for Kentucky Access coverage. As used in this paragraph, "eligible for" includes any individual and an individual's spouse or dependent who was eligible for coverage but waived that coverage. That individual and the individual's spouse or dependent shall be ineligible for Kentucky Access coverage through the period of waived coverage;

(b) The individual is eligible for coverage under Medicaid or Medicare;

(c) The individual previously terminated Kentucky Access coverage and twelve (12) months have not elapsed since the coverage was terminated, unless the individual demonstrates a good faith reason for the termination;

(d) Except for covered benefits paid under the standard health benefit plan as specified in KRS 304.17B-019, Kentucky Access has paid two million dollars ($2,000,000) in covered benefits per individual. The maximum limit under this paragraph may be increased by the office;

(e) The individual is confined to a public institution or incarcerated in a federal, state, or local penal institution or in the custody of federal, state, or local law enforcement authorities, including work release programs; or

(f) The individual's premium, deductible, coinsurance, or copayment is partially or entirely paid or reimbursed by an individual or entity other than the individual or the individual's parent, grandparent, spouse, child, stepchild, father-in-law, mother-in-law, son-in-law, daughter-in-law, sibling, brother-in-law, sister-in-law, grandchild, guardian, or court-appointed payor.

(5) The coverage of any person who ceases to meet the requirements of this section or the requirements of any administrative regulation promulgated under this subtitle may be terminated.

(6) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 12. KRS 304.17B-019 is amended to read as follows:

(1) Kentucky Access shall offer at least three (3) health benefit plans to enrollees, which shall be similar to the health benefit plans currently being marketed to individuals in the individual market.

(2) At least one (1) plan shall be offered in a traditional fee-for-service form. At least one (1) plan may be offered in a managed-care form at such time as the Office of Health Data and Analytics can establish an appropriate provider network in available service areas.

(3) The office shall provide for utilization review and case management for all health benefit plans issued under Kentucky Access.

(4) The office shall review and compare health benefit plans provided under Kentucky Access to health benefit plans provided in the individual market. Based on the review, the office may amend or replace the health benefit plans issued under Kentucky Access.

(5) Individuals who apply and are determined eligible for health benefit plans issued under Kentucky Access shall have coverage effective the first day of the month after the application month.

(6) For eligible individuals, health benefit plans issued under Kentucky Access shall

not impose any pre-existing condition exclusions. In all other cases, a pre-existing condition exclusion may be imposed in accordance with KRS 304.17A-230.

(7) Health benefit plans issued under Kentucky Access shall be guaranteed renewable except as otherwise specified in KRS 304.17B-015 and KRS 304.17A-240.

(8) All health benefit plans issued under Kentucky Access shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person covered in the contract may elect within sixty-three (63) days to continue under the same or a different contract.

(9) Health benefit plans issued under Kentucky Access shall coordinate benefits with other health benefit plans and be the payor of last resort.

(10) Health benefit plans issued under Kentucky Access shall pay covered benefits up to a lifetime limit of two million dollars ($2,000,000) per covered individual. The maximum limit under this subsection may be increased by the office.

(11) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 13. KRS 304.18-114 is amended to read as follows:

(1) As used in this section:

(a) "Conversion health insurance coverage" means a health benefit plan meeting the requirements of this section and regulated in accordance with Subtitles 17 and 17A of this chapter;

(b) "Group policy" has the meaning provided in KRS 304.18-110; and

(c) "Medicare" has the meaning provided in KRS 304.18-110.

(2) An insurer providing group health insurance coverage shall offer a conversion health insurance policy, by written notice, to any group member terminated under the group policy for any reason. The insurer shall offer a conversion health insurance policy substantially similar to the group policy. The former group member shall meet the following conditions:

(a) The former group member had been a member of the group and covered under

any health insurance policy offered by the group for at least three (3) months;

(b) The former group member must make written application to the insurer for conversion health insurance coverage not later than thirty-one (31) days after notice pursuant to subsection (5) of this section; and

(c) The former group member must pay the monthly, quarterly, semiannual, or annual premium, at the option of the applicant, to the insurer not later than thirty-one (31) days after notice pursuant to subsection (5) of this section.

(3) An insurer shall offer the following terms of conversion health insurance coverage:

(a) Conversion health insurance coverage shall be available without evidence of insurability and may contain a pre-existing condition limitation in accordance with KRS 304.17A-230;

(b) The premium for conversion health insurance coverage shall be according to the insurer's table of premium rates in effect on the latter of:

1. The effective date of the conversion policy; or

2. The date of application when the premium rate applies to the class of risk to which the covered persons belong, to their ages, and to the form and amount of insurance provided;

(c) The conversion health insurance policy shall cover the former group member and eligible dependents covered by the group policy on the date coverage under the group policy terminated.

(d) The effective date of the conversion health insurance policy shall be the date of termination of coverage under the group policy; and

(e) The conversion health insurance policy shall provide benefits substantially similar to those provided by the group policy, but not less than the minimum standards set forth in KRS 304.18-120 and any administrative regulations promulgated thereunder.

(4) Conversion health insurance coverage need not be granted in the following

situations:

(a) On the effective date of coverage, the applicant is or could be covered by Medicare;

(b) On the effective date of coverage, the applicant is or could be covered by another group coverage (insured or uninsured) or, the applicant is covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy; or

(c) The issuance of conversion health insurance coverage would cause the applicant to be overinsured according to the insurer's standards, taking into account that the applicant is or could be covered by similar benefits pursuant to or in accordance with the requirements of any statute and the individual coverage described in paragraph (b) of this subsection.

(5) Notice of the right to conversion health insurance coverage shall be given as follows:

(a) For group policies delivered, issued for delivery, or renewed after July 15, 2002, the insurer shall give written notice of the right to conversion health insurance coverage to any former group member entitled to conversion coverage under this section upon notice from the group policyholder that the group member has terminated membership in the group, upon termination of the former group member's continued group health insurance coverage pursuant to KRS 304.18-110 or COBRA as defined in KRS 304.17A-005~~[(7)]~~, or upon termination of the group policy for any reason. The written notice shall clearly explain the former group member's right to a conversion policy.

(b) The thirty-one (31) day period of subsection (2)(b) of this section shall not begin to run until the notice required by this subsection is mailed or delivered to the last known address of the former group member.

(c) If a former group member becomes entitled to obtain conversion health insurance coverage, pursuant to this section, and the insurer fails to give the former group member written notice of the right, pursuant to this subsection, the insurer shall give written notice to the former group member as soon as practicable after being notified of the insurer's failure to give written notice of conversion rights to the former group member and such former group member shall have an additional period within which to exercise his conversion rights. The additional period shall expire sixty (60) days after written notice is received from the insurer. Written notice delivered or mailed to the last known address of the former group member shall constitute the giving of notice for the purpose of this paragraph. If a former group member makes application and pays the premium, for conversion health insurance coverage within the additional period allowed by this paragraph, the effective date of conversion health insurance coverage shall be the date of termination of group health insurance coverage. However, nothing in this subsection shall require an insurer to give notice or provide conversion coverage to a former group member ninety (90) days after termination of the former group member's group coverage.

(6) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 14. KRS 304.18-120 is amended to read as follows:

(1) A converted policy issued pursuant to the conversion privilege contained in a group policy providing hospital or surgical expense insurance shall not impose a lifetime maximum benefit of less than five hundred thousand dollars ($500,000).

(2) The commissioner by administrative regulation shall establish minimum benefits for a converted policy issued pursuant to the conversion privilege contained in a group health policy.

(3) The provisions of this section shall be subject to Section 1 of this Act.

➔Section 15. KRS 18A.225 (Effective January 1, 2022) 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;
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(4)(c), 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.

(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~~[on or after June 29, 2021,]~~ 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) Section 1 of this Act; and

(l) ~~[(j)]~~ Administrative regulations promulgated pursuant to statutes listed in this subsection.

~~[(23) Any fully insured health benefit plan or self-insured plan issued or renewed on or after January 1, 2022, to public employees pursuant to this section shall comply with KRS 304.17A-148].~~

➔Section 16. KRS 164.2871 is amended to read as follows:

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

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

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

immunity or privilege.

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

(a) Conform to the requirements of Subtitle 32 of KRS Chapter 304***;*** and~~[shall]~~

(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 Section 1 of this Act.