

1 AN ACT relating to telehealth.

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

3 ➔SECTION 1. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO
4 READ AS FOLLOWS:

5 *(1) The cabinet shall provide oversight, guidance, and direction to Medicaid*
6 *providers delivering care using telehealth as defined in Section 2 of this Act.*

7 *(2) The cabinet shall:*

8 *(a) Develop policies and procedures to ensure the proper use and security for*
9 *telehealth, including but not limited to confidentiality and data integrity,*
10 *privacy and security, informed consent, privileging and credentialing,*
11 *reimbursement, and technology;*

12 *(b) Promote access to health care provided via telehealth;*

13 *(c) Maintain a list of Medicaid providers who may deliver telehealth services to*
14 *Medicaid recipients throughout the Commonwealth;*

15 *(d) Require that specialty care be rendered by a health care provider who is*
16 *recognized and actively participating in the Medicaid program; and*

17 *(e) Require that any required prior authorization requesting a referral or*
18 *consultation for specialty care be processed by the patient's primary care*
19 *provider and that any specialist coordinate care with the patient's primary*
20 *care provider.*

21 *(3) The cabinet or a Medicaid managed care organization shall not:*

22 *(a) Require a Medicaid provider to be physically present with a Medicaid*
23 *recipient, unless the provider determines that it is medically necessary to*
24 *perform those services in person;*

25 *(b) Require prior authorization, medical review, or administrative clearance for*
26 *telehealth that would not be required if a service were provided in person;*

27 *(c) Require a Medicaid provider to be employed by another provider or agency*

- 1 in order to provide telehealth services that would not be required if that
2 service were provided in person;
- 3 (d) Require demonstration that it is necessary to provide services to a Medicaid
4 recipient through telehealth;
- 5 (e) Restrict or deny coverage of telehealth based solely on the communication
6 technology or application used to deliver the telehealth services; or
- 7 (f) Require a Medicaid provider to be part of a telehealth network.
- 8 (4) The Medicaid program or a Medicaid managed care organization shall require a
9 telehealth provider to be licensed in Kentucky in order to receive reimbursement
10 for telehealth services.
- 11 (5) The Medicaid program or a Medicaid managed care organization shall reimburse
12 for covered services provided to a Medicaid recipient through telehealth, as
13 defined in Section 2 of this Act. The department shall promulgate administrative
14 regulations to establish requirements for telehealth coverage and reimbursement,
15 which shall be equivalent to the coverage for the same service provided in person
16 unless the telehealth provider and the Medicaid program or a Medicaid managed
17 care organization contractually agree to a lower reimbursement rate for
18 telehealth services, or the department establishes a different reimbursement rate.
- 19 (6) Benefits for a service provided to a Medicaid recipient through telehealth may be
20 made subject to a deductible, copayment, or coinsurance requirement. A
21 deductible, copayment, or coinsurance applicable to a particular service provided
22 through telehealth shall not exceed the deductible, copayment, or coinsurance
23 required by the Medicaid program for the same service provided in person.
- 24 (7) Nothing in this section shall be construed to require the Medicaid program or a
25 Medicaid managed care organization to:
- 26 (a) Provide coverage for telehealth services that are not medically necessary; or
27 (b) Reimburse any fees charged by a telehealth facility for transmission of a

1 telehealth encounter.

2 **(8) The cabinet shall maintain telehealth policies and guidelines to providing care**
3 **that ensure that Medicaid-eligible citizens will have safe, adequate, and efficient**
4 **medical care, and that prevent waste, fraud, and abuse of the Medicaid program.**

5 ➔Section 2. KRS 205.510 is amended to read as follows:

6 As used in this chapter as it pertains to medical assistance unless the context clearly
7 requires a different meaning:

- 8 (1) "Chiropractor" means a person authorized to practice chiropractic under KRS
9 Chapter 312;
- 10 (2) "Council" means the Advisory Council for Medical Assistance;
- 11 (3) "Dentist" means a person authorized to practice dentistry under laws of the
12 Commonwealth;
- 13 (4) "Health professional" means a physician, physician assistant, nurse, doctor of
14 chiropractic, mental health professional, optometrist, dentist, or allied health
15 professional who is licensed in Kentucky;
- 16 (5) "Medical care" as used in this chapter means essential medical, surgical,
17 chiropractic, dental, optometric, podiatric, telehealth, and nursing services, in the
18 home, office, clinic, or other suitable places, which are provided or prescribed by
19 physicians, optometrists, podiatrists, or dentists licensed to render such services,
20 including drugs and medical supplies, appliances, laboratory, diagnostic and
21 therapeutic services, nursing-home and convalescent care, hospital care as defined
22 in KRS 205.560(1)(a), and such other essential medical services and supplies as
23 may be prescribed by such persons; but not including abortions, or induced
24 miscarriages or premature births, unless in the opinion of a physician such
25 procedures are necessary for the preservation of the life of the woman seeking such
26 treatment or except in induced premature birth intended to produce a live viable
27 child and such procedure is necessary for the health of the mother or her unborn

- 1 child. However, this section does not authorize optometrists to perform any services
2 other than those authorized by KRS Chapter 320;
- 3 (6) "Nurse" means a person authorized to practice professional nursing under the laws
4 of the Commonwealth;
- 5 (7) "Nursing home" means a facility which provides routine medical care in which
6 physicians regularly visit patients, which provide nursing services and procedures
7 employed in caring for the sick which require training, judgment, technical
8 knowledge, and skills beyond that which the untrained person possesses, and which
9 maintains complete records on patient care, and which is licensed pursuant to the
10 provisions of KRS 216B.015;
- 11 (8) "Optometrist" means a person authorized to practice optometry under the laws of
12 the Commonwealth;
- 13 (9) "Other persons eligible for medical assistance" may include the categorically needy
14 excluded from money payment status by state requirements and classifications of
15 medically needy individuals as permitted by federal laws and regulations and as
16 prescribed by administrative regulation of the secretary for health and family
17 services or his designee;
- 18 (10) "Pharmacist" means a person authorized to practice pharmacy under the laws of the
19 Commonwealth;
- 20 (11) "Physician" means a person authorized to practice medicine or osteopathy under the
21 laws of the Commonwealth;
- 22 (12) "Podiatrist" means a person authorized to practice podiatry under the laws of the
23 Commonwealth;
- 24 (13) "Primary-care center" means a facility which provides comprehensive medical care
25 with emphasis on the prevention of disease and the maintenance of the patients'
26 health as opposed to the treatment of disease;
- 27 (14) "Public assistance recipient" means a person who has been certified by the

1 Department for Community Based Services of the Cabinet for Health and Family
 2 Services as being eligible for, and a recipient of, public assistance under the
 3 provisions of this chapter;

4 (15) "Telehealth":

5 (a) Means the delivery of health care-related services by a Medicaid provider
 6 who is a health care provider licensed in Kentucky to a Medicaid recipient
 7 through a face-to-face encounter with access to real-time interactive audio
 8 and video technology or store and forward services that are provided via
 9 asynchronous technologies as the standard practice of care where images
 10 are sent to a specialist for evaluation. The requirement for a face-to-face
 11 encounter shall be satisfied with the use of asynchronous
 12 telecommunications technologies in which the health care provider has
 13 access to the Medicaid recipient's medical history prior to the telehealth
 14 encounter;

15 (b) Shall not include the delivery of services through electronic mail, text chat,
 16 facsimile, or standard audio-only telephone call; and

17 (c) Shall be delivered over a secure communications connection that complies
 18 with the federal Health Insurance Portability and Accountability Act of
 19 1996, 42 U.S.C. secs. 1320d to 1320d-9;

20 (16) "Telehealth consultation" means a medical or health consultation, for purposes of
 21 patient diagnosis or treatment, that meets the definition of telehealth in this
 22 section~~requires the use of advanced telecommunications technology, including, but~~
 23 ~~not limited to:~~

24 ~~(a) Compressed digital interactive video, audio, or data transmission;~~

25 ~~(b) Clinical data transmission via computer imaging for teleradiology or~~
 26 ~~telepathology; and~~

27 ~~(c) Other technology that facilitates access to health care services or medical~~

1 ~~specialty expertise~~;

2 ~~(17)~~[(16)] "Third party" means an individual, institution, corporation, company,
 3 insurance company, personal representative, administrator, executor, trustee, or
 4 public or private agency, including, but not limited to, a reparation obligor and the
 5 assigned claims bureau under the Motor Vehicle Reparations Act, Subtitle 39 of
 6 KRS Chapter 304, who is or may be liable to pay all or part of the medical cost of
 7 injury, disease, or disability of an applicant or recipient of medical assistance
 8 provided under Title XIX of the Social Security Act, 42 U.S.C. sec. 1396 et seq.;

9 and
 10 ~~(18)~~[(17)] "Vendor payment" means a payment for medical care which is paid by the
 11 Cabinet for Health and Family Services directly to the authorized person or
 12 institution which rendered medical care to an eligible recipient.

13 ➔Section 3. KRS 205.559 is amended to read as follows:

14 (1) The Cabinet for Health and Family Services and any regional managed care
 15 partnership or other entity under contract with the cabinet for the administration or
 16 provision of the Medicaid program shall provide Medicaid reimbursement for a
 17 telehealth consultation as defined in Section 2 of this Act that is provided by a
 18 Medicaid-participating practitioner who is licensed in Kentucky~~—and that is~~
 19 ~~provided in the telehealth network established in KRS 194A.125(3)(b)]~~.

20 (2) (a) The cabinet shall establish reimbursement rates for telehealth consultations. A
 21 request for reimbursement shall not be denied solely because an in-person
 22 consultation between a Medicaid-participating practitioner and a patient did
 23 not occur.

24 (b) A telehealth consultation shall not be reimbursable under this section if it is
 25 provided through the use of an audio-only telephone, facsimile machine, or
 26 electronic mail.

27 (3) A health-care facility that receives reimbursement under this section for

1 consultations provided by a Medicaid-participating provider who practices in that
2 facility and a health professional who obtains a consultation under this section shall
3 establish quality-of-care protocols and patient confidentiality guidelines to ensure
4 that telehealth consultations meet all requirements and patient care standards as
5 required by law.

6 (4) The cabinet shall not require a telehealth consultation if an in-person consultation
7 with a Medicaid-participating provider is reasonably available where the patient
8 resides, works, or attends school or if the patient prefers an in-person consultation.

9 (5) The cabinet shall request any waivers of federal laws or regulations that may be
10 necessary to implement this section.

11 (6) (a) The cabinet and any regional managed care partnership or other entity under
12 contract with the cabinet for the administration or provision of the Medicaid
13 program shall study the impact of this section on the health care delivery
14 system in Kentucky and shall, upon implementation, issue an annual~~a~~
15 ~~quarterly~~ report to the Legislative Research Commission. This report shall
16 include an analysis of:

- 17 1. The economic impact of this section on the Medicaid budget, including
18 any costs or savings as a result of decreased transportation expenditures
19 and office or emergency room visits;
- 20 2. The quality of care as a result of telehealth consultations rendered under
21 this section; and
- 22 3. Any other issues deemed relevant by the cabinet.

23 (b) In addition to the analysis required under paragraph (a) of this subsection, the
24 cabinet report shall compare telehealth reimbursement and delivery among all
25 regional managed care partnerships or other entities under contract with the
26 cabinet for the administration or provision of the Medicaid program.

27 (7) The cabinet shall promulgate an administrative regulation in accordance with KRS

1 Chapter 13A to designate the claim forms, records required, and authorization
2 procedures to be followed in conjunction with this section.

3 ➔Section 4. KRS 304.17A-005 is amended to read as follows:

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

- 5 (1) "Association" means an entity, other than an employer-organized association, that
6 has been organized and is maintained in good faith for purposes other than that of
7 obtaining insurance for its members and that has a constitution and bylaws;
- 8 (2) "At the time of enrollment" means:
- 9 (a) At the time of application for an individual, an association that actively
10 markets to individual members, and an employer-organized association that
11 actively markets to individual members; and
- 12 (b) During the time of open enrollment or during an insured's initial or special
13 enrollment periods for group health insurance;
- 14 (3) "Base premium rate" means, for each class of business as to a rating period, the
15 lowest premium rate charged or that could have been charged under the rating
16 system for that class of business by the insurer to the individual or small group, or
17 employer as defined in KRS 304.17A-0954, with similar case characteristics for
18 health benefit plans with the same or similar coverage;
- 19 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,
20 or employer-organized association that limits coverage to physician, pharmacy,
21 home health, preventive, emergency, and inpatient and outpatient hospital services
22 in accordance with the requirements of this subtitle. If vision or eye services are
23 offered, these services may be provided by an ophthalmologist or optometrist.
24 Chiropractic benefits may be offered by providers licensed pursuant to KRS
25 Chapter 312;
- 26 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
27 91(d)(3);

- 1 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
- 2 (7) "COBRA" means any of the following:
- 3 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
- 4 vaccines;
- 5 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
- 6 et seq. other than sec. 1169); or
- 7 (c) 42 U.S.C. sec. 300bb;
- 8 (8) (a) "Creditable coverage" means, with respect to an individual, coverage of the
- 9 individual under any of the following:
- 10 1. A group health plan;
- 11 2. Health insurance coverage;
- 12 3. Part A or Part B of Title XVIII of the Social Security Act;
- 13 4. Title XIX of the Social Security Act, other than coverage consisting
- 14 solely of benefits under section 1928;
- 15 5. Chapter 55 of Title 10, United States Code, including medical and dental
- 16 care for members and certain former members of the uniformed services,
- 17 and for their dependents; for purposes of Chapter 55 of Title 10, United
- 18 States Code, "uniformed services" means the Armed Forces and the
- 19 Commissioned Corps of the National Oceanic and Atmospheric
- 20 Administration and of the Public Health Service;
- 21 6. A medical care program of the Indian Health Service or of a tribal
- 22 organization;
- 23 7. A state health benefits risk pool;
- 24 8. A health plan offered under Chapter 89 of Title 5, United States Code,
- 25 such as the Federal Employees Health Benefit Program;
- 26 9. A public health plan as established or maintained by a state, the United
- 27 States government, a foreign country, or any political subdivision of a

1 state, the United States government, or a foreign country that provides
2 health coverage to individuals who are enrolled in the plan;

3 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
4 U.S.C. sec. 2504(e)); or

5 11. Title XXI of the Social Security Act, such as the State Children's Health
6 Insurance Program.

7 (b) This term does not include coverage consisting solely of coverage of excepted
8 benefits as defined in subsection (14) of this section;

9 (9) "Dependent" means any individual who is or may become eligible for coverage
10 under the terms of an individual or group health benefit plan because of a
11 relationship to a participant;

12 (10) "Employee benefit plan" means an employee welfare benefit plan or an employee
13 pension benefit plan or a plan which is both an employee welfare benefit plan and
14 an employee pension benefit plan as defined by ERISA;

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

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

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

- 1 (c) With respect to whom the most recent coverage within the coverage period
2 described in paragraph (a) of this subsection was not terminated based on a
3 factor described in KRS 304.17A-240(2)(a), (b), and (c);
- 4 (d) If the individual had been offered the option of continuation coverage under a
5 COBRA continuation provision or under KRS 304.18-110, who elected the
6 coverage; and
- 7 (e) Who, if the individual elected the continuation coverage, has exhausted the
8 continuation coverage under the provision or program;
- 9 (12) "Employer-organized association" means any of the following:
- 10 (a) Any entity that was qualified by the commissioner as an eligible association
11 prior to April 10, 1998, and that has actively marketed a health insurance
12 program to its members since September 8, 1996, and which is not insurer-
13 controlled;
- 14 (b) Any entity organized under KRS 247.240 to 247.370 that has actively
15 marketed health insurance to its members and that is not insurer-controlled; or
- 16 (c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-
17 91(d)(3), whose members consist principally of employers, and for which the
18 entity's health insurance decisions are made by a board or committee, the
19 majority of which are representatives of employer members of the entity who
20 obtain group health insurance coverage through the entity or through a trust or
21 other mechanism established by the entity, and whose health insurance
22 decisions are reflected in written minutes or other written documentation.

23 Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, and
24 except as otherwise provided by the definition of "large group" contained in
25 subsection (30) of this section, an employer-organized association shall not be
26 treated as an association, small group, or large group under this subtitle, provided
27 that an employer-organized association that is a bona fide association as defined in

1 subsection (5) of this section shall be treated as a large group under this subtitle;

2 (13) "Employer-organized association health insurance plan" means any health insurance
3 plan, policy, or contract issued to an employer-organized association, or to a trust
4 established by one (1) or more employer-organized associations, or providing
5 coverage solely for the employees, retired employees, directors and their spouses
6 and dependents of the members of one (1) or more employer-organized
7 associations;

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

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

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

13 (c) Liability insurance, including general liability insurance and automobile
14 liability insurance;

15 (d) Workers' compensation or similar insurance;

16 (e) Automobile medical payment insurance;

17 (f) Credit-only insurance;

18 (g) Coverage for on-site medical clinics;

19 (h) Other similar insurance coverage, specified in administrative regulations,
20 under which benefits for medical care are secondary or incidental to other
21 insurance benefits;

22 (i) Limited scope dental or vision benefits;

23 (j) Benefits for long-term care, nursing home care, home health care, community-
24 based care, or any combination thereof;

25 (k) Such other similar, limited benefits as are specified in administrative
26 regulations;

27 (l) Coverage only for a specified disease or illness;

- 1 (m) Hospital indemnity or other fixed indemnity insurance;
- 2 (n) Benefits offered as Medicare supplemental health insurance, as defined under
3 section 1882(g)(1) of the Social Security Act;
- 4 (o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10,
5 United States Code;
- 6 (p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is
7 supplemental to coverage under a group health plan; and
- 8 (q) Health flexible spending arrangements;
- 9 (15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec.
10 1002(32);
- 11 (16) "Group health plan" means a plan, including a self-insured plan, of or contributed to
12 by an employer, including a self-employed person, or employee organization, to
13 provide health care directly or otherwise to the employees, former employees, the
14 employer, or others associated or formerly associated with the employer in a
15 business relationship, or their families;
- 16 (17) "Guaranteed acceptance program participating insurer" means an insurer that is
17 required to or has agreed to offer health benefit plans in the individual market to
18 guaranteed acceptance program qualified individuals under KRS 304.17A-400 to
19 304.17A-480;
- 20 (18) "Guaranteed acceptance program plan" means a health benefit plan in the individual
21 market issued by an insurer that provides health benefits to a guaranteed acceptance
22 program qualified individual and is eligible for assessment and refunds under the
23 guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;
- 24 (19) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance
25 Program established and operated under KRS 304.17A-400 to 304.17A-480;
- 26 (20) "Guaranteed acceptance program qualified individual" means an individual who, on
27 or before December 31, 2000:

- 1 (a) Is not an eligible individual;
- 2 (b) Is not eligible for or covered by other health benefit plan coverage or who is a
- 3 spouse or a dependent of an individual who:
- 4 1. Waived coverage under KRS 304.17A-210(2); or
- 5 2. Did not elect family coverage that was available through the association
- 6 or group market;
- 7 (c) Within the previous three (3) years has been diagnosed with or treated for a
- 8 high-cost condition or has had benefits paid under a health benefit plan for a
- 9 high-cost condition, or is a high risk individual as defined by the underwriting
- 10 criteria applied by an insurer under the alternative underwriting mechanism
- 11 established in KRS 304.17A-430(3);
- 12 (d) Has been a resident of Kentucky for at least twelve (12) months immediately
- 13 preceding the effective date of the policy; and
- 14 (e) Has not had his or her most recent coverage under any health benefit plan
- 15 terminated or nonrenewed because of any of the following:
- 16 1. The individual failed to pay premiums or contributions in accordance
- 17 with the terms of the plan or the insurer had not received timely
- 18 premium payments;
- 19 2. The individual performed an act or practice that constitutes fraud or
- 20 made an intentional misrepresentation of material fact under the terms of
- 21 the coverage; or
- 22 3. The individual engaged in intentional and abusive noncompliance with
- 23 health benefit plan provisions;
- 24 (21) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or
- 25 before December 31, 2000, that is not a guaranteed acceptance plan participating
- 26 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
- 27 guaranteed acceptance plan supporting insurer shall not include an employer-

- 1 sponsored self-insured health benefit plan exempted by ERISA;
- 2 (22) "Health benefit plan" means any hospital or medical expense policy or certificate;
- 3 nonprofit hospital, medical-surgical, and health service corporation contract or
- 4 certificate; provider sponsored integrated health delivery network; a self-insured
- 5 plan or a plan provided by a multiple employer welfare arrangement, to the extent
- 6 permitted by ERISA; health maintenance organization contract; or any health
- 7 benefit plan that affects the rights of a Kentucky insured and bears a reasonable
- 8 relation to Kentucky, whether delivered or issued for delivery in Kentucky, and
- 9 does not include policies covering only accident, credit, dental, disability income,
- 10 fixed indemnity medical expense reimbursement policy, long-term care, Medicare
- 11 supplement, specified disease, vision care, coverage issued as a supplement to
- 12 liability insurance, insurance arising out of a workers' compensation or similar law,
- 13 automobile medical-payment insurance, insurance under which benefits are payable
- 14 with or without regard to fault and that is statutorily required to be contained in any
- 15 liability insurance policy or equivalent self-insurance, short-term coverage, student
- 16 health insurance offered by a Kentucky-licensed insurer under written contract with
- 17 a university or college whose students it proposes to insure, medical expense
- 18 reimbursement policies specifically designed to fill gaps in primary coverage,
- 19 coinsurance, or deductibles and provided under a separate policy, certificate, or
- 20 contract, or coverage supplemental to the coverage provided under Chapter 55 of
- 21 Title 10, United States Code, or limited health service benefit plans, or direct
- 22 primary care agreements established under KRS 311.6201, 311.6202, 314.198, and
- 23 314.199;
- 24 (23) "Health care provider" or "provider" means any facility or service required to be
- 25 licensed pursuant to KRS Chapter 216B, a pharmacist as defined pursuant to KRS
- 26 Chapter 315, or home medical equipment and services provider as defined pursuant
- 27 to KRS 309.402, and any of the following independent practicing practitioners:

- 1 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;
- 2 (b) Chiropractors licensed under KRS Chapter 312;
- 3 (c) Dentists licensed under KRS Chapter 313;
- 4 (d) Optometrists licensed under KRS Chapter 320;
- 5 (e) Physician assistants regulated under KRS Chapter 311;
- 6 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and
- 7 (g) Other health care practitioners as determined by the department by
- 8 administrative regulations promulgated under KRS Chapter 13A;
- 9 (24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
- 10 Program, means a covered condition in an individual policy as listed in
- 11 paragraph (c) of this subsection or as added by the commissioner in
- 12 accordance with KRS 304.17A-280, but only to the extent that the condition
- 13 exceeds the numerical score or rating established pursuant to uniform
- 14 underwriting standards prescribed by the commissioner under paragraph (b) of
- 15 this subsection that account for the severity of the condition and the cost
- 16 associated with treating that condition.
- 17 (b) The commissioner by administrative regulation shall establish uniform
- 18 underwriting standards and a score or rating above which a condition is
- 19 considered to be high-cost by using:
- 20 1. Codes in the most recent version of the "International Classification of
- 21 Diseases" that correspond to the medical conditions in paragraph (c) of
- 22 this subsection and the costs for administering treatment for the
- 23 conditions represented by those codes; and
- 24 2. The most recent version of the questionnaire incorporated in a national
- 25 underwriting guide generally accepted in the insurance industry as
- 26 designated by the commissioner, the scoring scale for which shall be
- 27 established by the commissioner.

- 1 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
2 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
3 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
4 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
5 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
6 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,
7 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
8 stroke, syringomyelia, and Wilson's disease;
- 9 (25) "Index rate" means, for each class of business as to a rating period, the arithmetic
10 average of the applicable base premium rate and the corresponding highest premium
11 rate;
- 12 (26) "Individual market" means the market for the health insurance coverage offered to
13 individuals other than in connection with a group health plan. The individual market
14 includes an association plan that is not employer related, issued to individuals on an
15 individually underwritten basis, other than an employer-organized association or a
16 bona fide association, that has been organized and is maintained in good faith for
17 purposes other than obtaining insurance for its members and that has a constitution
18 and bylaws;
- 19 (27) "Insurer" means any insurance company; health maintenance organization; self-
20 insurer or multiple employer welfare arrangement not exempt from state regulation
21 by ERISA; provider-sponsored integrated health delivery network; self-insured
22 employer-organized association, or nonprofit hospital, medical-surgical, dental, or
23 health service corporation authorized to transact health insurance business in
24 Kentucky;
- 25 (28) "Insurer-controlled" means that the commissioner has found, in an administrative
26 hearing called specifically for that purpose, that an insurer has or had a substantial
27 involvement in the organization or day-to-day operation of the entity for the

- 1 principal purpose of creating a device, arrangement, or scheme by which the insurer
2 segments employer groups according to their actual or anticipated health status or
3 actual or projected health insurance premiums;
- 4 (29) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);
- 5 (30) "Large group" means:
- 6 (a) An employer with fifty-one (51) or more employees;
- 7 (b) An affiliated group with fifty-one (51) or more eligible members; or
- 8 (c) An employer-organized association that is a bona fide association as defined
9 in subsection (5) of this section;
- 10 (31) "Managed care" means systems or techniques generally used by third-party payors
11 or their agents to affect access to and control payment for health care services and
12 that integrate the financing and delivery of appropriate health care services to
13 covered persons by arrangements with participating providers who are selected to
14 participate on the basis of explicit standards for furnishing a comprehensive set of
15 health care services and financial incentives for covered persons using the
16 participating providers and procedures provided for in the plan;
- 17 (32) "Market segment" means the portion of the market covering one (1) of the
18 following:
- 19 (a) Individual;
- 20 (b) Small group;
- 21 (c) Large group; or
- 22 (d) Association;
- 23 (33) "Participant" means any employee or former employee of an employer, or any
24 member or former member of an employee organization, who is or may become
25 eligible to receive a benefit of any type from an employee benefit plan which covers
26 employees of the employer or members of the organization, or whose beneficiaries
27 may be eligible to receive any benefit as established in Section 3(7) of ERISA;

- 1 (34) "Preventive services" means medical services for the early detection of disease that
2 are associated with substantial reduction in morbidity and mortality;
- 3 (35) "Provider network" means an affiliated group of varied health care providers that is
4 established to provide a continuum of health care services to individuals;
- 5 (36) "Provider-sponsored integrated health delivery network" means any provider-
6 sponsored integrated health delivery network created and qualified under KRS
7 304.17A-300 and KRS 304.17A-310;
- 8 (37) "Purchaser" means an individual, organization, employer, association, or the
9 Commonwealth that makes health benefit purchasing decisions on behalf of a group
10 of individuals;
- 11 (38) "Rating period" means the calendar period for which premium rates are in effect. A
12 rating period shall not be required to be a calendar year;
- 13 (39) "Restricted provider network" means a health benefit plan that conditions the
14 payment of benefits, in whole or in part, on the use of the providers that have
15 entered into a contractual arrangement with the insurer to provide health care
16 services to covered individuals;
- 17 (40) "Self-insured plan" means a group health insurance plan in which the sponsoring
18 organization assumes the financial risk of paying for covered services provided to
19 its enrollees;
- 20 (41) "Small employer" means, in connection with a group health plan with respect to a
21 calendar year and a plan year, an employer who employed an average of at least two
22 (2) but not more than fifty (50) employees on business days during the preceding
23 calendar year and who employs at least two (2) employees on the first day of the
24 plan year;
- 25 (42) "Small group" means:
- 26 (a) A small employer with two (2) to fifty (50) employees; or
- 27 (b) An affiliated group or association with two (2) to fifty (50) eligible members;

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

2 (44) "Telehealth":

3 (a) Means the delivery of health care-related services by a health care provider
 4 who is licensed in Kentucky to a patient or client through a face-to-face
 5 encounter with access to real-time interactive audio and video technology or
 6 store and forward services that are provided via asynchronous technologies
 7 as the standard practice of care where images are sent to a specialist for
 8 evaluation. The requirement for a face-to-face encounter shall be satisfied
 9 with the use of asynchronous telecommunications technologies in which the
 10 health care provider has access to the patient's or client's medical history
 11 prior to the telehealth encounter;

12 (b) Shall not include the delivery of services through electronic mail, text chat,
 13 facsimile, or standard audio-only telephone call; and

14 (c) Shall be delivered over a secure communications connection that complies
 15 with the federal Health Insurance Portability and Accountability Act of
 16 1996, 42 U.S.C. secs. 1320d to 1320d-9~~[has the meaning provided in KRS~~
 17 ~~311.550].~~

18 ➔Section 5. KRS 304.17A-138 is amended to read as follows:

19 (1) (a) A health benefit plan shall reimburse for covered services provided to an
 20 insured person through telehealth as defined in Section 4 of this Act.
 21 Telehealth coverage and reimbursement shall be equivalent to the coverage
 22 for the same service provided in person unless the telehealth provider and
 23 the health benefit plan contractually agree to a lower reimbursement rate
 24 for telehealth services~~[not exclude a service from coverage solely because the~~
 25 ~~service is provided through telehealth and not provided through a face-to-face~~
 26 ~~consultation if the consultation is provided through the telehealth network~~
 27 ~~established under KRS 194A.125. A health benefit plan may provide coverage~~

1 for a consultation at a site not within the telehealth network at the discretion
2 of the insurer].

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

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

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

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

12 **4. Require a provider to be employed by another provider or agency in**
13 **order to provide telehealth services that would not be required if that**
14 **service were provided in person;**

15 **5. Restrict or deny coverage of telehealth based solely on the**
16 **communication technology or application used to deliver the**
17 **telehealth services; or**

18 **6. Require a provider to be part of a telehealth network**~~[A telehealth
19 consultation shall not be reimbursable under this section if it is provided
20 through the use of an audio-only telephone, facsimile machine, or
21 electronic mail].~~

22 (2) **A health benefit plan shall require a telehealth provider to be licensed in**
23 **Kentucky in order to receive reimbursement for telehealth services.**

24 **(3)** Benefits for a service provided through telehealth required by this section may be
25 made subject to a deductible, copayment, or coinsurance requirement. A deductible,
26 copayment, or coinsurance applicable to a particular service provided through
27 telehealth shall not exceed the deductible, copayment, or coinsurance required by

1 the health benefit plan for the same service provided in person~~[through a face-to-~~
 2 ~~face consultation]~~.

3 ~~(4)~~~~(3)~~ **Nothing in this section shall be construed to require a health benefit plan**
 4 **to:**

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

6 **(b) Reimburse any fees charged by a telehealth facility for transmission of a**
 7 **telehealth encounter.**

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

10 ~~(6)~~~~(4)~~ The department shall promulgate an administrative regulation in accordance
 11 with KRS Chapter 13A to designate the claim forms and records required to be
 12 maintained in conjunction with this section.

13 ➔Section 6. KRS 342.315 is amended to read as follows:

14 (1) The commissioner shall contract with the University of Kentucky and the
 15 University of Louisville medical schools to evaluate workers who have had injuries
 16 or become affected by occupational diseases covered by this chapter. Referral for
 17 evaluation may be made to one (1) of the medical schools whenever a medical
 18 question is at issue.

19 (2) The physicians and institutions performing evaluations pursuant to this section shall
 20 render reports encompassing their findings and opinions in the form prescribed by
 21 the commissioner. Except as otherwise provided in KRS 342.316, the clinical
 22 findings and opinions of the designated evaluator shall be afforded presumptive
 23 weight by administrative law judges and the burden to overcome such findings and
 24 opinions shall fall on the opponent of that evidence. When administrative law
 25 judges reject the clinical findings and opinions of the designated evaluator, they
 26 shall specifically state in the order the reasons for rejecting that evidence.

27 (3) The commissioner or an administrative law judge may, upon the application of any

1 party or upon his own motion, direct appointment by the commissioner, pursuant to
2 subsection (1) of this section, of a medical evaluator to make any necessary medical
3 examination of the employee. Such medical evaluator shall file with the
4 commissioner within fifteen (15) days after such examination a written report. The
5 medical evaluator appointed may charge a reasonable fee not exceeding fees
6 established by the commissioner for those services.

7 (4) Within thirty (30) days of the receipt of a statement for the evaluation, the employer
8 or carrier shall pay the cost of the examination. Upon notice from the commissioner
9 that an evaluation has been scheduled, the insurance carrier shall forward within
10 seven (7) days to the employee the expenses of travel necessary to attend the
11 evaluation at a rate equal to that paid to state employees for travel by private
12 automobile while conducting state business.

13 (5) Upon claims in which it is finally determined that the injured worker was not the
14 employee at the time of injury of an employer covered by this chapter, the special
15 fund shall reimburse the carrier for any evaluation performed pursuant to this
16 section for which the carrier has been erroneously compelled to make payment.

17 (6) Not less often than annually the designee of the secretary of the Cabinet for Health
18 and Family Services shall assess the performance of the medical schools and render
19 findings as to whether evaluations conducted under this section are being rendered
20 in a timely manner, whether examinations are conducted in accordance with
21 medically recognized techniques, whether impairment ratings are in conformity
22 with standards prescribed by the "Guides to the Evaluation of Permanent
23 Impairment," and whether coal workers' pneumoconiosis examinations are
24 conducted in accordance with the standards prescribed in this chapter.

25 (7) The General Assembly finds that good public policy mandates the realization of the
26 potential advantages, both economic and effectual, of the use of ~~telemedicine and~~
27 ~~telehealth~~. The commissioner may, to the extent that he or she finds it feasible and

1 appropriate, require the use of ~~[telemedicine and]~~ telehealth~~[practices]~~, as ***defined***
2 ***in Section 4 of this Act***~~[authorized under KRS 194A.125]~~, in the independent
3 medical evaluation process required by this chapter.

4 ➔Section 7. 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
 18 on or after July 12, 2006, to public employees shall comply with KRS 304.17A-600
 19 to 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, 2019, to public employees pursuant to this section shall comply with**
 26 **Section 5 of this Act.**

27 ➔SECTION 8. A NEW SECTION OF KRS 311.710 TO 311.820 IS CREATED

1 TO READ AS FOLLOWS:

2 *A physician performing or inducing an abortion shall be present in person and in the*
3 *same room with the patient. The use of telehealth as defined in Section 4 of this*
4 *Act shall not be allowed in the performance of an abortion.*

5 ➔Section 9. KRS 311.990 is amended to read as follows:

- 6 (1) Any person who violates KRS 311.250 shall be guilty of a violation.
- 7 (2) Any college or professor thereof violating the provisions of KRS 311.300 to
8 311.350 shall be civilly liable on his bond for a sum not less than one hundred
9 dollars (\$100) nor more than one thousand dollars (\$1,000) for each violation,
10 which may be recovered by an action in the name of the Commonwealth.
- 11 (3) Any person who presents to the county clerk for the purpose of registration any
12 license which has been fraudulently obtained, or obtains any license under KRS
13 311.380 to 311.510 by false or fraudulent statement or representation, or practices
14 podiatry under a false or assumed name or falsely impersonates another practitioner
15 or former practitioner of a like or different name, or aids and abets any person in the
16 practice of podiatry within the state without conforming to the requirements of KRS
17 311.380 to 311.510, or otherwise violates or neglects to comply with any of the
18 provisions of KRS 311.380 to 311.510, shall be guilty of a Class A misdemeanor.
19 Each case of practicing podiatry in violation of the provisions of KRS 311.380 to
20 311.510 shall be considered a separate offense.
- 21 (4) Each violation of KRS 311.560 shall constitute a Class D felony.
- 22 (5) Each violation of KRS 311.590 shall constitute a Class D felony. Conviction under
23 this subsection of a holder of a license or permit shall result automatically in
24 permanent revocation of such license or permit.
- 25 (6) Conviction of willfully resisting, preventing, impeding, obstructing, threatening, or
26 interfering with the board or any of its members, or of any officer, agent, inspector,
27 or investigator of the board or the Cabinet for Health and Family Services, in the

1 administration of any of the provisions of KRS 311.550 to 311.620 shall be a Class
2 A misdemeanor.

3 (7) Each violation of subsection (1) of KRS 311.375 shall, for the first offense, be a
4 Class B misdemeanor, and, for each subsequent offense shall be a Class A
5 misdemeanor.

6 (8) Each violation of subsection (2) of KRS 311.375 shall, for the first offense, be a
7 violation, and, for each subsequent offense, be a Class B misdemeanor.

8 (9) Each day of violation of either subsection of KRS 311.375 shall constitute a
9 separate offense.

10 (10) (a) Any person who intentionally or knowingly performs an abortion contrary to
11 the requirements of KRS 311.723(1) shall be guilty of a Class D felony; and

12 (b) Any person who intentionally, knowingly, or recklessly violates the
13 requirements of KRS 311.723(2) shall be guilty of a Class A misdemeanor.

14 (11) (a) 1. Any physician who performs a partial-birth abortion in violation of KRS
15 311.765 shall be guilty of a Class D felony. However, a physician shall
16 not be guilty of the criminal offense if the partial-birth abortion was
17 necessary to save the life of the mother whose life was endangered by a
18 physical disorder, illness, or injury.

19 2. A physician may seek a hearing before the State Board of Medical
20 Licensure on whether the physician's conduct was necessary to save the
21 life of the mother whose life was endangered by a physical disorder,
22 illness, or injury. The board's findings, decided by majority vote of a
23 quorum, shall be admissible at the trial of the physician. The board shall
24 promulgate administrative regulations to carry out the provisions of this
25 subparagraph.

26 3. Upon a motion of the physician, the court shall delay the beginning of
27 the trial for not more than thirty (30) days to permit the hearing, referred

1 to in subparagraph 2. of this paragraph, to occur.

2 (b) Any person other than a physician who performs a partial-birth abortion shall
3 not be prosecuted under this subsection but shall be prosecuted under
4 provisions of law which prohibit any person other than a physician from
5 performing any abortion.

6 (c) No penalty shall be assessed against the woman upon whom the partial-birth
7 abortion is performed or attempted to be performed.

8 (12) Any person who intentionally performs an abortion with knowledge that, or with
9 reckless disregard as to whether, the person upon whom the abortion is to be
10 performed is an unemancipated minor, and who intentionally or knowingly fails to
11 conform to any requirement of KRS 311.732 is guilty of a Class A misdemeanor.

12 (13) Any person who negligently releases information or documents which are
13 confidential under KRS 311.732 is guilty of a Class B misdemeanor.

14 (14) Any person who performs an abortion upon a married woman either with
15 knowledge or in reckless disregard of whether KRS 311.735 applies to her and who
16 intentionally, knowingly, or recklessly fails to conform to the requirements of KRS
17 311.735 shall be guilty of a Class D felony.

18 (15) Any person convicted of violating KRS 311.750 shall be guilty of a Class B felony.

19 (16) Any person who violates KRS 311.760(2) shall be guilty of a Class D felony.

20 (17) Any person who violates KRS 311.770 or 311.780 shall be guilty of a Class D
21 felony.

22 (18) A person convicted of violating KRS 311.780 shall be guilty of a Class C felony.

23 (19) Except as provided in KRS 311.782(6), any person who intentionally violates KRS
24 311.782 shall be guilty of a Class D felony.

25 (20) Any person who violates KRS 311.783(1) shall be guilty of a Class B misdemeanor.

26 (21) Any person who violates KRS 311.810 shall be guilty of a Class A misdemeanor.

27 (22) Any professional medical association or society, licensed physician, or hospital or

1 hospital medical staff who shall have violated the provisions of KRS 311.606 shall
2 be guilty of a Class B misdemeanor.

3 (23) Any administrator, officer, or employee of a publicly owned hospital or publicly
4 owned health care facility who performs or permits the performance of abortions in
5 violation of KRS 311.800(1) shall be guilty of a Class A misdemeanor.

6 (24) Any person who violates KRS 311.905(3) shall be guilty of a violation.

7 (25) Any person who violates the provisions of KRS 311.820 shall be guilty of a Class A
8 misdemeanor.

9 (26) (a) Any person who fails to test organs, skin, or other human tissue which is to be
10 transplanted, or violates the confidentiality provisions required by KRS
11 311.281, shall be guilty of a Class A misdemeanor.

12 (b) Any person who has human immunodeficiency virus infection, who knows he
13 is infected with human immunodeficiency virus, and who has been informed
14 that he may communicate the infection by donating organs, skin, or other
15 human tissue who donates organs, skin, or other human tissue shall be guilty
16 of a Class D felony.

17 (27) Any person who sells or makes a charge for any transplantable organ shall be guilty
18 of a Class D felony.

19 (28) Any person who offers remuneration for any transplantable organ for use in
20 transplantation into himself shall be fined not less than five thousand dollars
21 (\$5,000) nor more than fifty thousand dollars (\$50,000).

22 (29) Any person brokering the sale or transfer of any transplantable organ shall be guilty
23 of a Class C felony.

24 (30) Any person charging a fee associated with the transplantation of a transplantable
25 organ in excess of the direct and indirect costs of procuring, distributing, or
26 transplanting the transplantable organ shall be fined not less than fifty thousand
27 dollars (\$50,000) nor more than five hundred thousand dollars (\$500,000).

1 (31) Any hospital performing transplantable organ transplants which knowingly fails to
2 report the possible sale, purchase, or brokering of a transplantable organ shall be
3 fined not less than ten thousand dollars (\$10,000) or more than fifty thousand
4 dollars (\$50,000).

5 (32) (a) Any physician or qualified technician who violates KRS 311.727 shall be
6 fined not more than one hundred thousand dollars (\$100,000) for a first
7 offense and not more than two hundred fifty thousand dollars (\$250,000) for
8 each subsequent offense.

9 (b) In addition to the fine, the court shall report the violation of any physician, in
10 writing, to the Kentucky Board of Medical Licensure for such action and
11 discipline as the board deems appropriate.

12 (33) Any person who violates KRS 311.691 shall be guilty of a Class B misdemeanor for
13 the first offense, and a Class A misdemeanor for a second or subsequent offense. In
14 addition to any other penalty imposed for that violation, the board may, through the
15 Attorney General, petition a Circuit Court to enjoin the person who is violating
16 KRS 311.691 from practicing genetic counseling in violation of the requirements of
17 KRS 311.690 to 311.700.

18 **(34) Any person convicted of violating Section 8 of this Act shall be guilty of a Class D**
19 **felony.**

20 ➔Section 10. The following KRS section is repealed:

21 194A.125 Telehealth Board -- Members -- Chair -- Scope of administrative regulations --
22 - Board to make recommendations following consultation with Governor's office --
23 Universities of Kentucky and Louisville to report to General Assembly -- Receipt
24 and dispensing of funds.

25 ➔Section 11. This Act takes effect July 1, 2019.