

1 AN ACT relating to coverage for the care of children.

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

3 ➔Section 1. KRS 304.17A-258 is amended to read as follows:

4 (1) **As used in**~~For purposes of~~ this section:

5 (a) "Therapeutic food, formulas, and supplements" means products intended for
6 the dietary treatment of inborn errors of metabolism or genetic conditions,
7 including but not limited to eosinophilic disorders, food protein allergies, food
8 protein-induced enterocolitis syndrome, mitochondrial disease, and short
9 bowel disorders, under the direction of a physician, and includes amino acid-
10 based elemental formula and the use of vitamin and nutritional supplements
11 such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2,
12 vitamin K1, and L-carnitine;

13 (b) "Low-protein modified food" means a product formulated to have less than
14 one (1) gram of protein per serving and intended for the dietary treatment of
15 inborn errors of metabolism or genetic conditions under the direction of a
16 physician; and

17 (c) "Amino acid-based elemental formula" means a product intended for the
18 diagnosis and dietary treatment of eosinophilic disorders, food protein
19 allergies, food protein-induced enterocolitis, and short **bowel**~~bowel~~
20 syndrome under the direction of a physician.

21 (2) **(a)** A health benefit plan that provides prescription drug coverage shall include in
22 that coverage therapeutic food, formulas, supplements, and low-protein
23 modified food products for the treatment of inborn errors of metabolism or
24 genetic conditions, including those that are compounded, if the therapeutic
25 food, formulas, supplements, and low-protein modified food products are
26 obtained for the therapeutic treatment of inborn errors of metabolism or
27 genetic conditions, including but not limited to mitochondrial disease, under

1 the direction of a physician.

2 **(b) Except as provided in subsection (4) of this section,** coverage under this
3 subsection may be subject, for each plan year, to a cap of twenty-five
4 thousand dollars (\$25,000) for therapeutic food, formulas, and supplements
5 and a separate cap for each plan year of four thousand dollars (\$4,000) ~~for~~
6 low-protein modified foods. ~~[Each cap shall be subject to annual inflation~~
7 ~~adjustments based on the consumer price index.]~~

8 **(c)** Coverage under this ~~subsection~~ shall not be denied because two (2)
9 or more supplements are compounded.

10 (3) **(a) To the extent that coverage is not provided under subsection (2) of this**
11 **section or KRS 304.17A-139, a health benefit plan shall provide coverage**
12 **for enteral infant and baby formulas prescribed by a physician in a written**
13 **order, which states that the formula:**

14 **1. Is medically necessary; and**

15 **2. Has been proven effective as a disease-specific treatment regimen** ~~[The~~
16 ~~requirements of this section shall apply to all health benefit plans issued~~
17 ~~or renewed on and after January 1, 2017].~~

18 **(b) Except as provided in subsection (4) of this section, coverage under this**
19 **subsection may be subject to, for each plan year, a cap of three thousand**
20 **dollars (\$3,000).**

21 (4) **Any cap imposed on coverage required under subsection (2) or (3) of this section**
22 **shall be subject to annual inflation adjustments based on the nonseasonally**
23 **adjusted annual average Consumer Price Index for All Urban Consumers (CPI-**
24 **U), U.S. City Average, All Items, as published by the United States Bureau of**
25 **Labor Statistics** ~~[Nothing in this section or KRS 205.560, 213.141, or 214.155 shall~~
26 ~~be construed to require a health benefit plan to provide coverage for therapeutic~~
27 ~~foods, formulas, supplements, or low protein modified food for the treatment of~~

1 ~~lactose intolerance, protein intolerance, food allergy, food sensitivity, or any other~~
2 ~~condition or disease that is not an inborn error of metabolism or genetic condition].~~

3 (5) If the application of any requirement of this section would be the sole cause of a
4 health benefit plan's failure to qualify as a Health Savings Account-qualified
5 High Deductible Health Plan under 26 U.S.C. sec. 223, as amended, then the
6 requirement shall not apply to that health benefit plan until the minimum
7 deductible under 26 U.S.C. sec. 223, as amended, is satisfied.

8 (6) Notwithstanding KRS 304.17A-099 and any other provision of this chapter, if the
9 application of any requirement of this section to a qualified health plan, as
10 defined in 42 U.S.C. sec. 18021(a)(1), as amended, results, or would result, in a
11 determination that the state must make payments to defray the cost of the
12 requirement under 42 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as
13 amended, then the requirement shall not apply to the qualified health plan until
14 the requirement to make cost defrayal payments is no longer applicable.

15 ➔Section 2. KRS 304.17A-145 is amended to read as follows:

16 (1) As used in this section:

17 (a) "Health benefit plan" has the same meaning as in KRS 304.17A-005, except
18 for purposes of this section, the term:

- 19 1. Includes student health insurance offered by a Kentucky-licensed insurer
20 under written contract with a university or college whose students it
21 proposes to insure; and
- 22 2. Does not include a group health benefit plan that provides grandfathered
23 health plan coverage as defined in 45 C.F.R. sec. 147.140(a), as
24 amended;

25 (b) "In-home program" means a program offered by a health care facility or
26 health care professional for the treatment of substance use disorder which the
27 insured accesses through telehealth or digital health services; and

- 1 (c) "Telehealth" or "digital health" has the same meaning as in KRS 211.332.
- 2 (2) Except as provided for in subsection (5) of this section:
- 3 (a) A health benefit plan shall provide maternity coverage; and
- 4 (b) The coverage required by this subsection includes coverage for:
- 5 1. All individuals covered under the plan, including dependents, regardless
- 6 of age;
- 7 2. Maternity care associated with pregnancy, childbirth, and postpartum
- 8 care;
- 9 3. Labor and delivery;
- 10 4. In conjunction with each birth and without a prescription, all
- 11 breastfeeding services and supplies required under 42 U.S.C. sec.
- 12 300gg-13(a) and any related federal regulations, as amended; and
- 13 5. Except as provided in subsection (3) of this section, inpatient care for a
- 14 mother and her newly born child for a minimum of:
- 15 a. Forty-eight (48) hours after vaginal delivery; or
- 16 b. Ninety-six (96) hours after delivery by Cesarean section.
- 17 (3) The provisions of subsection (2)(b)5. of this section shall not apply to a health
- 18 benefit plan if:
- 19 (a) The plan authorizes an initial postpartum home visit which would include the
- 20 collection of an adequate sample for the hereditary and metabolic newborn
- 21 screening; and
- 22 (b) The attending physician, with the consent of the mother of the newly born
- 23 child, authorizes a shorter length of stay upon the physician's determination
- 24 that the mother and newborn meet the criteria for medical stability in the most
- 25 current version of "Guidelines for Perinatal Care" prepared by the American
- 26 Academy of Pediatrics and the American College of Obstetricians and
- 27 Gynecologists.

1 (4) Except as provided for in subsection (5) of this section, a health benefit plan shall
2 provide coverage:

3 (a) To pregnant and postpartum women for an in-home program; and

4 (b) For telehealth or digital health services that are related to maternity care
5 associated with pregnancy, childbirth, and postpartum care.

6 (5) If the application of any requirement of this section to a qualified health plan as
7 defined in 42 U.S.C. sec. 18021(a)(1), as amended, would result in a determination
8 that the state must make payments to defray the cost of the requirement under 42
9 U.S.C. sec. 18031(d)(3) and 45 C.F.R. sec. 155.170, as amended, then the
10 requirement shall not apply to the qualified health plan until the cost defrayal
11 requirement is no longer applicable.

12 ➔Section 3. KRS 205.522 is amended to read as follows:

13 (1) With respect to the administration and provision of Medicaid benefits pursuant to
14 this chapter, the Department for Medicaid Services, any managed care organization
15 contracted to provide Medicaid benefits pursuant to this chapter, and the state's
16 medical assistance program shall be subject to, and comply with, the following, as
17 applicable:

18 (a) KRS 304.17A-129;

19 (b) KRS 304.17A-145;

20 (c) KRS 304.17A-163;

21 (d) KRS 304.17A-1631;

22 (e) KRS 304.17A-167;

23 (f) KRS 304.17A-235;

24 (g) KRS 304.17A-257;

25 (h) KRS 304.17A-259;

26 (i) KRS 304.17A-263;

27 (j) KRS 304.17A-264;

- 1 (k) KRS 304.17A-515;
2 (l) KRS 304.17A-580;
3 (m) KRS 304.17A-600, 304.17A-603, and 304.17A-607;~~and~~
4 (n) KRS 304.17A-740 to 304.17A-743; and
5 (o) Section 1 of this Act.

- 6 (2) A managed care organization contracted to provide Medicaid benefits pursuant to
7 this chapter shall comply with the reporting requirements of KRS 304.17A-732.

8 ➔Section 4. KRS 205.560 is amended to read as follows:

- 9 (1) The scope of medical care for which the Cabinet for Health and Family Services
10 undertakes to pay shall be designated and limited by regulations promulgated by the
11 cabinet, pursuant to the provisions in this section. Within the limitations of any
12 appropriation therefor, the provision of complete upper and lower dentures to
13 recipients of Medical Assistance Program benefits who have their teeth removed by
14 a dentist resulting in the total absence of teeth shall be a mandatory class in the
15 scope of medical care. Payment to a dentist of any Medical Assistance Program
16 benefits for complete upper and lower dentures shall only be provided on the
17 condition of a preauthorized agreement between an authorized representative of the
18 Medical Assistance Program and the dentist prior to the removal of the teeth. The
19 selection of another class or other classes of medical care shall be recommended by
20 the council to the secretary for health and family services after taking into
21 consideration, among other things, the amount of federal and state funds available,
22 the most essential needs of recipients, and the meeting of such need on a basis
23 insuring the greatest amount of medical care as defined in KRS 205.510 consonant
24 with the funds available, including but not limited to the following categories,
25 except where the aid is for the purpose of obtaining an abortion:
26 (a) Hospital care, including drugs, and medical supplies and services during any
27 period of actual hospitalization;

1 (b) Nursing-home care, including medical supplies and services, and drugs during
2 confinement therein on prescription of a physician, dentist, or podiatrist;

3 (c) Drugs, nursing care, medical supplies, and services during the time when a
4 recipient is not in a hospital but is under treatment and on the prescription of a
5 physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall
6 include those products covered under Section 1 of this Act ~~for the treatment~~
7 ~~of inborn errors of metabolism or genetic, gastrointestinal, and food-allergic~~
8 ~~conditions, consisting of therapeutic food, formulas, supplements, amino acid-~~
9 ~~based elemental formula, or low protein modified food products that are~~
10 ~~medically indicated for therapeutic treatment and are administered under the~~
11 ~~direction of a physician,]~~ and include but ~~are~~ not be limited to products for
12 the following conditions:

- 13 1. Phenylketonuria;
- 14 2. Hyperphenylalaninemia;
- 15 3. Tyrosinemia (types I, II, and III);
- 16 4. Maple syrup urine disease;
- 17 5. A-ketoacid dehydrogenase deficiency;
- 18 6. Isovaleryl-CoA dehydrogenase deficiency;
- 19 7. 3-methylcrotonyl-CoA carboxylase deficiency;
- 20 8. 3-methylglutaconyl-CoA hydratase deficiency;
- 21 9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase
- 22 deficiency);
- 23 10. B-ketothiolase deficiency;
- 24 11. Homocystinuria;
- 25 12. Glutaric aciduria (types I and II);
- 26 13. Lysinuric protein intolerance;
- 27 14. Non-ketotic hyperglycinemia;

- 1 15. Propionic acidemia;
- 2 16. Gyrate atrophy;
- 3 17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
- 4 18. Carbamoyl phosphate synthetase deficiency;
- 5 19. Ornithine carbamoyl transferase deficiency;
- 6 20. Citrullinemia;
- 7 21. Arginosuccinic aciduria;
- 8 22. Methylmalonic acidemia;
- 9 23. Argininemia;
- 10 24. Food protein allergies;
- 11 25. Food protein-induced enterocolitis syndrome;
- 12 26. Eosinophilic disorders; and
- 13 27. Short bowel syndrome;
- 14 (d) Physician, podiatric, and dental services;
- 15 (e) Optometric services for all age groups shall be limited to prescription
- 16 services, services to frames and lenses, and diagnostic services provided by an
- 17 optometrist, to the extent the optometrist is licensed to perform the services
- 18 and to the extent the services are covered in the ophthalmologist portion of the
- 19 physician's program. Eyeglasses shall be provided only to children under age
- 20 twenty-one (21);
- 21 (f) Drugs on the prescription of a physician used to prevent the rejection of
- 22 transplanted organs if the patient is indigent; and
- 23 (g) Nonprofit neighborhood health organizations or clinics where some or all of
- 24 the medical services are provided by licensed registered nurses or by
- 25 advanced medical students presently enrolled in a medical school accredited
- 26 by the Association of American Medical Colleges and where the students or
- 27 licensed registered nurses are under the direct supervision of a licensed

1 physician who rotates his or her services in this supervisory capacity between
2 two (2) or more of the nonprofit neighborhood health organizations or clinics
3 specified in this paragraph.

4 (2) Payments for hospital care, nursing-home care, and drugs or other medical,
5 ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount
6 of the payment to the cost of providing the services or supplies. It shall be one (1)
7 of the functions of the council to make recommendations to the Cabinet for Health
8 and Family Services with respect to the bases for payment. In determining the rates
9 of reimbursement for long-term-care facilities participating in the Medical
10 Assistance Program, the Cabinet for Health and Family Services shall, to the extent
11 permitted by federal law, not allow the following items to be considered as a cost to
12 the facility for purposes of reimbursement:

13 (a) Motor vehicles that are not owned by the facility, including motor vehicles
14 that are registered or owned by the facility but used primarily by the owner or
15 family members thereof;

16 (b) The cost of motor vehicles, including vans or trucks, used for facility business
17 shall be allowed up to fifteen thousand dollars (\$15,000) per facility, adjusted
18 annually for inflation according to the increase in the consumer price index-u
19 for the most recent twelve (12) month period, as determined by the United
20 States Department of Labor. Medically equipped motor vehicles, vans, or
21 trucks shall be exempt from the fifteen thousand dollar (\$15,000) limitation.
22 Costs exceeding this limit shall not be reimbursable and shall be borne by the
23 facility. Costs for additional motor vehicles, not to exceed a total of three (3)
24 per facility, may be approved by the Cabinet for Health and Family Services if
25 the facility demonstrates that each additional vehicle is necessary for the
26 operation of the facility as required by regulations of the cabinet;

27 (c) Salaries paid to immediate family members of the owner or administrator, or

1 both, of a facility, to the extent that services are not actually performed and
2 are not a necessary function as required by regulation of the cabinet for the
3 operation of the facility. The facility shall keep a record of all work actually
4 performed by family members;

5 (d) The cost of contracts, loans, or other payments made by the facility to owners,
6 administrators, or both, unless the payments are for services which would
7 otherwise be necessary to the operation of the facility and the services are
8 required by regulations of the Cabinet for Health and Family Services. Any
9 other payments shall be deemed part of the owner's compensation in
10 accordance with maximum limits established by regulations of the Cabinet for
11 Health and Family Services. Interest paid to the facility for loans made to a
12 third party may be used to offset allowable interest claimed by the facility;

13 (e) Private club memberships for owners or administrators, travel expenses for
14 trips outside the state for owners or administrators, and other indirect
15 payments made to the owner, unless the payments are deemed part of the
16 owner's compensation in accordance with maximum limits established by
17 regulations of the Cabinet for Health and Family Services; and

18 (f) Payments made to related organizations supplying the facility with goods or
19 services shall be limited to the actual cost of the goods or services to the
20 related organization, unless it can be demonstrated that no relationship
21 between the facility and the supplier exists. A relationship shall be considered
22 to exist when an individual, including brothers, sisters, father, mother, aunts,
23 uncles, and in-laws, possesses a total of five percent (5%) or more of
24 ownership equity in the facility and the supplying business. An exception to
25 the relationship shall exist if fifty-one percent (51%) or more of the supplier's
26 business activity of the type carried on with the facility is transacted with
27 persons and organizations other than the facility and its related organizations.

- 1 (3) No vendor payment shall be made unless the class and type of medical care
2 rendered and the cost basis therefor has first been designated by regulation.
- 3 (4) The rules and regulations of the Cabinet for Health and Family Services shall
4 require that a written statement, including the required opinion of a physician, shall
5 accompany any claim for reimbursement for induced premature births. This
6 statement shall indicate the procedures used in providing the medical services.
- 7 (5) The range of medical care benefit standards provided and the quality and quantity
8 standards and the methods for determining cost formulae for vendor payments
9 within each category of public assistance and other recipients shall be uniform for
10 the entire state, and shall be designated by regulation promulgated within the
11 limitations established by the Social Security Act and federal regulations. It shall
12 not be necessary that the amount of payments for units of services be uniform for
13 the entire state but amounts may vary from county to county and from city to city,
14 as well as among hospitals, based on the prevailing cost of medical care in each
15 locale and other local economic and geographic conditions, except that insofar as
16 allowed by applicable federal law and regulation, the maximum amounts
17 reimbursable for similar services rendered by physicians within the same specialty
18 of medical practice shall not vary according to the physician's place of residence or
19 place of practice, as long as the place of practice is within the boundaries of the
20 state.
- 21 (6) Nothing in this section shall be deemed to deprive a woman of all appropriate
22 medical care necessary to prevent her physical death.
- 23 (7) To the extent permitted by federal law, no medical assistance recipient shall be
24 recertified as qualifying for a level of long-term care below the recipient's current
25 level, unless the recertification includes a physical examination conducted by a
26 physician licensed pursuant to KRS Chapter 311 or by an advanced practice
27 registered nurse licensed pursuant to KRS Chapter 314 and acting under the

- 1 physician's supervision.
- 2 (8) (a) If payments made to community mental health centers, established pursuant to
3 KRS Chapter 210, for services provided to the intellectually disabled exceed
4 the actual cost of providing the service, the balance of the payments shall be
5 used solely for the provision of other services to the intellectually disabled
6 through community mental health centers.
- 7 (b) Except as provided in KRS 210.370(4) and (5)(c), if a community mental
8 health center, established pursuant to KRS Chapter 210, provides services to a
9 recipient of Medical Assistance Program benefits outside of the community
10 mental health center's regional service area, as established in KRS 210.370,
11 the community mental health center shall not be reimbursed for such services
12 in accordance with the department's fee schedule for community mental
13 health centers but shall instead be reimbursed in accordance with the
14 department's fee schedule for behavioral health service organizations.
- 15 (c) As used in this subsection, "community mental health center" means a
16 regional community services program as defined in KRS 210.005.
- 17 (9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to
18 recipients of medical assistance under Title XIX of the Social Security Act on July
19 15, 1986, shall deny admission of a person to a bed certified for reimbursement
20 under the provisions of the Medical Assistance Program solely on the basis of the
21 person's paying status as a Medicaid recipient. No person shall be removed or
22 discharged from any facility solely because they became eligible for participation in
23 the Medical Assistance Program, unless the facility can demonstrate the resident or
24 the resident's responsible party was fully notified in writing that the resident was
25 being admitted to a bed not certified for Medicaid reimbursement. No facility may
26 decertify a bed occupied by a Medicaid recipient or may decertify a bed that is
27 occupied by a resident who has made application for medical assistance.

- 1 (10) Family-practice physicians practicing in geographic areas with no more than one
2 (1) primary-care physician per five thousand (5,000) population, as reported by the
3 United States Department of Health and Human Services, shall be reimbursed one
4 hundred twenty-five percent (125%) of the standard reimbursement rate for
5 physician services.
- 6 (11) The Cabinet for Health and Family Services shall make payments under the
7 Medical Assistance Program for services which are within the lawful scope of
8 practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the
9 Medical Assistance Program pays for the same services provided by a physician.
- 10 (12) (a) The Medical Assistance Program shall use the appropriate form and
11 guidelines for enrolling those providers applying for participation in the
12 Medical Assistance Program, including those licensed and regulated under
13 KRS Chapters 311, 312, 314, 315, and 320, any facility required to be
14 licensed pursuant to KRS Chapter 216B, and any other health care practitioner
15 or facility as determined by the Department for Medicaid Services through an
16 administrative regulation promulgated under KRS Chapter 13A. A Medicaid
17 managed care organization shall use the forms and guidelines established
18 under KRS 304.17A-545(5) to credential a provider. For any provider who
19 contracts with and is credentialed by a Medicaid managed care organization
20 prior to enrollment, the cabinet shall complete the enrollment process and
21 deny, or approve and issue a Provider Identification Number (PID) within
22 fifteen (15) business days from the time all necessary completed enrollment
23 forms have been submitted and all outstanding accounts receivable have been
24 satisfied.
- 25 (b) Within forty-five (45) days of receiving a correct and complete provider
26 application, the Department for Medicaid Services shall complete the
27 enrollment process by either denying or approving and issuing a Provider

1 Identification Number (PID) for a behavioral health provider who provides
2 substance use disorder services, unless the department notifies the provider
3 that additional time is needed to render a decision for resolution of an issue or
4 dispute.

5 (c) Within forty-five (45) days of receipt of a correct and complete application for
6 credentialing by a behavioral health provider providing substance use disorder
7 services, a Medicaid managed care organization shall complete its contracting
8 and credentialing process, unless the Medicaid managed care organization
9 notifies the provider that additional time is needed to render a decision. If
10 additional time is needed, the Medicaid managed care organization shall not
11 take any longer than ninety (90) days from receipt of the credentialing
12 application to deny or approve and contract with the provider.

13 (d) A Medicaid managed care organization shall adjudicate any clean claims
14 submitted for a substance use disorder service from an enrolled and
15 credentialed behavioral health provider who provides substance use disorder
16 services in accordance with KRS 304.17A-700 to 304.17A-730.

17 (e) The Department of Insurance may impose a civil penalty of one hundred
18 dollars (\$100) per violation when a Medicaid managed care organization fails
19 to comply with this section. Each day that a Medicaid managed care
20 organization fails to pay a claim may count as a separate violation.

21 (13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements
22 of subsection (12) of this section. The Department for Medicaid Services shall
23 develop a specific form and establish guidelines for assessing the credentials of
24 dentists applying for participation in the Medical Assistance Program.

25 ➔Section 5. KRS 205.6485 is amended to read as follows:

26 (1) As used in this section, "KCHIP" means the Kentucky Children's Health Insurance
27 Program.

- 1 (2) The Cabinet for Health and Family Services shall:
- 2 (a) Prepare a state child health plan, known as KCHIP, meeting the requirements
- 3 of Title XXI of the Federal Social Security Act, for submission to the
- 4 Secretary of the United States Department of Health and Human Services
- 5 within such time as will permit the state to receive the maximum amounts of
- 6 federal matching funds available under Title XXI; and
- 7 (b) By administrative regulation promulgated in accordance with KRS Chapter
- 8 13A, establish the following:
- 9 1. The eligibility criteria for children covered by KCHIP, which shall
- 10 include a provision that no person eligible for services under Title XIX
- 11 of the Social Security Act, 42 U.S.C. secs. 1396 to 1396v, as amended,
- 12 shall be eligible for services under KCHIP, except to the extent that
- 13 Title XIX coverage is expanded by KRS 205.6481 to 205.6495 and KRS
- 14 304.17A-340;
- 15 2. The schedule of benefits to be covered by KCHIP, which shall:
- 16 a. Be at least equivalent to one (1) of the following:
- 17 i. The standard Blue Cross/Blue Shield preferred provider
- 18 option under the Federal Employees Health Benefit Plan
- 19 established by 5 U.S.C. sec. 8903(1);
- 20 ii. A mid-range health benefit coverage plan that is offered and
- 21 generally available to state employees; or
- 22 iii. Health insurance coverage offered by a health maintenance
- 23 organization that has the largest insured commercial, non-
- 24 Medicaid enrollment of covered lives in the state; and
- 25 b. Comply with subsection (6) of this section;
- 26 3. The premium contribution per family for health insurance coverage
- 27 available under KCHIP, which shall be based:

- 1 a. On a six (6) month period; and
- 2 b. Upon a sliding scale relating to family income not to exceed:
 - 3 i. Ten dollars (\$10), to be paid by a family with income
 - 4 between one hundred percent (100%) to one hundred thirty-
 - 5 three percent (133%) of the federal poverty level;
 - 6 ii. Twenty dollars (\$20), to be paid by a family with income
 - 7 between one hundred thirty-four percent (134%) to one
 - 8 hundred forty-nine percent (149%) of the federal poverty
 - 9 level; and
 - 10 iii. One hundred twenty dollars (\$120), to be paid by a family
 - 11 with income between one hundred fifty percent (150%) to
 - 12 two hundred percent (200%) of the federal poverty level, and
 - 13 which may be made on a partial payment plan of twenty
 - 14 dollars (\$20) per month or sixty dollars (\$60) per quarter;
- 15 4. There shall be no copayments for services provided under KCHIP; and
- 16 5. a. The criteria for health services providers and insurers wishing to
- 17 contract with the Commonwealth to provide coverage under
- 18 KCHIP.
- 19 b. The cabinet shall provide, in any contracting process for coverage
- 20 of preventive services, the opportunity for a public health
- 21 department to bid on preventive health services to eligible children
- 22 within the public health department's service area. A public health
- 23 department shall not be disqualified from bidding because the
- 24 department does not currently offer all the services required by
- 25 this section. The criteria shall be set forth in administrative
- 26 regulations under KRS Chapter 13A and shall maximize
- 27 competition among the providers and insurers. The Finance and

1 Administration Cabinet shall provide oversight over contracting
2 policies and procedures to assure that the number of applicants for
3 contracts is maximized.

4 (3) Within twelve (12) months of federal approval of the state's Title XXI child health
5 plan, the Cabinet for Health and Family Services shall assure that a KCHIP
6 program is available to all eligible children in all regions of the state. If necessary,
7 in order to meet this assurance, the cabinet shall institute its own program.

8 (4) KCHIP recipients shall have direct access without a referral from any gatekeeper
9 primary care provider to dentists for covered primary dental services and to
10 optometrists and ophthalmologists for covered primary eye and vision services.

11 (5) KCHIP shall comply with KRS 304.17A-163 and 304.17A-1631.

12 (6) The schedule of benefits required under subsection (2)(b)2. of this section shall
13 include:

14 (a) Preventive services;

15 (b) Vision services, including glasses;

16 (c) Dental services, including sealants, extractions, and fillings; and

17 (d) The coverage required under:

18 1. KRS 304.17A-129;~~and~~

19 2. KRS 304.17A-145; and

20 3. Section 1 of this Act.

21 ➔Section 6. KRS 164.2871 is amended to read as follows:

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

- 1 (2) All retirement annuity allowances accrued or accruing to any employee of a state
2 postsecondary educational institution through a retirement program sponsored by
3 the state postsecondary educational institution are hereby exempt from any state,
4 county, or municipal tax, and shall not be subject to execution, attachment,
5 garnishment, or any other process whatsoever, nor shall any assignment thereof be
6 enforceable in any court. Except retirement benefits accrued or accruing to any
7 employee of a state postsecondary educational institution through a retirement
8 program sponsored by the state postsecondary educational institution on or after
9 January 1, 1998, shall be subject to the tax imposed by KRS 141.020, to the extent
10 provided in KRS 141.010 and 141.0215.
- 11 (3) Except as provided in KRS Chapter 44, the purchase of liability insurance for
12 members of governing boards, faculty and staff of institutions of higher education
13 in this state shall not be construed to be a waiver of sovereign immunity or any
14 other immunity or privilege.
- 15 (4) The governing board of each state postsecondary education institution is authorized
16 to provide a self-insured employer group health plan to its employees, which plan
17 shall:
- 18 (a) Conform to the requirements of Subtitle 32 of KRS Chapter 304; and
19 (b) Except as provided in subsection (5) of this section, be exempt from
20 conformity with Subtitle 17A of KRS Chapter 304.
- 21 (5) A self-insured employer group health plan provided by the governing board of a
22 state postsecondary education institution to its employees shall comply with:
- 23 (a) KRS 304.17A-129;
24 (b) KRS 304.17A-133;
25 (c) KRS 304.17A-145;
26 (d) KRS 304.17A-163 and 304.17A-1631;
27 (e) KRS 304.17A-261;

- 1 (f) KRS 304.17A-262;
2 (g) KRS 304.17A-264;~~and~~
3 (h) KRS 304.17A-265; and
4 (i) Section 1 of this Act.

- 5 (6) (a) A self-insured employer group health plan provided by the governing board of
6 a state postsecondary education institution to its employees shall provide a
7 special enrollment period to pregnant women who are eligible for coverage in
8 accordance with the requirements set forth in KRS 304.17-182.
9 (b) The governing board of a state postsecondary education institution shall, at or
10 before the time an employee is initially offered the opportunity to enroll in the
11 plan or coverage, provide the employee a notice of the special enrollment
12 rights under this subsection.

13 ➔Section 7. KRS 18A.225 is amended to read as follows:

- 14 (1) (a) The term "employee" for purposes of this section means:
15 1. Any person, including an elected public official, who is regularly
16 employed by any department, office, board, agency, or branch of state
17 government; or by a public postsecondary educational institution; or by
18 any city, urban-county, charter county, county, or consolidated local
19 government, whose legislative body has opted to participate in the state-
20 sponsored health insurance program pursuant to KRS 79.080; and who
21 is either a contributing member to any one (1) of the retirement systems
22 administered by the state, including but not limited to the Kentucky
23 Retirement Systems, County Employees Retirement System, Kentucky
24 Teachers' Retirement System, the Legislators' Retirement Plan, or the
25 Judicial Retirement Plan; or is receiving a contractual contribution from
26 the state toward a retirement plan; or, in the case of a public
27 postsecondary education institution, is an individual participating in an

- 1 optional retirement plan authorized by KRS 161.567; or is eligible to
2 participate in a retirement plan established by an employer who ceases
3 participating in the Kentucky Employees Retirement System pursuant to
4 KRS 61.522 whose employees participated in the health insurance plans
5 administered by the Personnel Cabinet prior to the employer's effective
6 cessation date in the Kentucky Employees Retirement System;
- 7 2. Any certified or classified employee of a local board of education or a
8 public charter school as defined in KRS 160.1590;
- 9 3. Any elected member of a local board of education;
- 10 4. Any person who is a present or future recipient of a retirement
11 allowance from the Kentucky Retirement Systems, County Employees
12 Retirement System, Kentucky Teachers' Retirement System, the
13 Legislators' Retirement Plan, the Judicial Retirement Plan, or the
14 Kentucky Community and Technical College System's optional
15 retirement plan authorized by KRS 161.567, except that a person who is
16 receiving a retirement allowance and who is age sixty-five (65) or older
17 shall not be included, with the exception of persons covered under KRS
18 61.702(2)(b)3. and 78.5536(2)(b)3., unless he or she is actively
19 employed pursuant to subparagraph 1. of this paragraph; and
- 20 5. Any eligible dependents and beneficiaries of participating employees
21 and retirees who are entitled to participate in the state-sponsored health
22 insurance program;
- 23 (b) The term "health benefit plan" for the purposes of this section means a health
24 benefit plan as defined in KRS 304.17A-005;
- 25 (c) The term "insurer" for the purposes of this section means an insurer as defined
26 in KRS 304.17A-005; and
- 27 (d) The term "managed care plan" for the purposes of this section means a

1 managed care plan as defined in KRS 304.17A-500.

2 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
3 recommendation of the secretary of the Personnel Cabinet, shall procure, in
4 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
5 from one (1) or more insurers authorized to do business in this state, a group
6 health benefit plan that may include but not be limited to health maintenance
7 organization (HMO), preferred provider organization (PPO), point of service
8 (POS), and exclusive provider organization (EPO) benefit plans
9 encompassing all or any class or classes of employees. With the exception of
10 employers governed by the provisions of KRS Chapters 16, 18A, and 151B,
11 all employers of any class of employees or former employees shall enter into
12 a contract with the Personnel Cabinet prior to including that group in the state
13 health insurance group. The contracts shall include but not be limited to
14 designating the entity responsible for filing any federal forms, adoption of
15 policies required for proper plan administration, acceptance of the contractual
16 provisions with health insurance carriers or third-party administrators, and
17 adoption of the payment and reimbursement methods necessary for efficient
18 administration of the health insurance program. Health insurance coverage
19 provided to state employees under this section shall, at a minimum, contain
20 the same benefits as provided under Kentucky Kare Standard as of January 1,
21 1994, and shall include a mail-order drug option as provided in subsection
22 (13) of this section. All employees and other persons for whom the health care
23 coverage is provided or made available shall annually be given an option to
24 elect health care coverage through a self-funded plan offered by the
25 Commonwealth or, if a self-funded plan is not available, from a list of
26 coverage options determined by the competitive bid process under the
27 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available

1 during annual open enrollment.

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

5 (c) Any carrier bidding to offer health care coverage to employees shall agree to
6 provide coverage to all members of the state group, including active
7 employees and retirees and their eligible covered dependents and
8 beneficiaries, within the county or counties specified in its bid. Except as
9 provided in subsection (19)~~[(20)]~~ of this section, any carrier bidding to offer
10 health care coverage to employees shall also agree to rate all employees as a
11 single entity, except for those retirees whose former employers insure their
12 active employees outside the state-sponsored health insurance program and as
13 otherwise provided in KRS 61.702(2)(b)3.b. and 78.5536(2)(b)3.b.

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

24 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities
25 for timely analysis of data received from carriers and, to the extent possible,
26 provide in the request-for-proposal specifics relating to data requirements,
27 electronic reporting, and penalties for noncompliance. The Commonwealth

1 shall own the enrollment, claims, and utilization data provided by each carrier
2 and shall develop methods to protect the confidentiality of the individual. The
3 Personnel Cabinet shall include in the October annual report submitted
4 pursuant to the provisions of KRS 18A.226 to the Governor, the General
5 Assembly, and the Chief Justice of the Supreme Court, an analysis of the
6 financial stability of the program, which shall include but not be limited to
7 loss ratios, methods of risk adjustment, measurements of carrier quality of
8 service, prescription coverage and cost management, and statutorily required
9 mandates. If state self-insurance was available as a carrier option, the report
10 also shall provide a detailed financial analysis of the self-insurance fund
11 including but not limited to loss ratios, reserves, and reinsurance agreements.

12 (f) If any agency participating in the state-sponsored employee health insurance
13 program for its active employees terminates participation and there is a state
14 appropriation for the employer's contribution for active employees' health
15 insurance coverage, then neither the agency nor the employees shall receive
16 the state-funded contribution after termination from the state-sponsored
17 employee health insurance program.

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

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

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

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

1 otherwise;

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

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

10 (4) If an employee moves his or her place of residence or employment out of the
11 service area of an insurer offering a managed health care plan, under which he or
12 she has elected coverage, into either the service area of another managed health care
13 plan or into an area of the Commonwealth not within a managed health care plan
14 service area, the employee shall be given an option, at the time of the move or
15 transfer, to change his or her coverage to another health benefit plan.

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

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

- 1 (7) Group rates under this section shall be made available to the disabled child of an
2 employee regardless of the child's age if the entire premium for the disabled child's
3 coverage is paid by the state employee. A child shall be considered disabled if he or
4 she has been determined to be eligible for federal Social Security disability benefits.
- 5 (8) The health care contract or contracts for employees shall be entered into for a
6 period of not less than one (1) year.
- 7 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
8 State Health Insurance Subscribers to advise the secretary or the secretary's
9 designee regarding the state-sponsored health insurance program for employees.
10 The secretary shall appoint, from a list of names submitted by appointing
11 authorities, members representing school districts from each of the seven (7)
12 Supreme Court districts, members representing state government from each of the
13 seven (7) Supreme Court districts, two (2) members representing retirees under age
14 sixty-five (65), one (1) member representing local health departments, two (2)
15 members representing the Kentucky Teachers' Retirement System, and three (3)
16 members at large. The secretary shall also appoint two (2) members from a list of
17 five (5) names submitted by the Kentucky Education Association, two (2) members
18 from a list of five (5) names submitted by the largest state employee organization of
19 nonschool state employees, two (2) members from a list of five (5) names submitted
20 by the Kentucky Association of Counties, two (2) members from a list of five (5)
21 names submitted by the Kentucky League of Cities, and two (2) members from a
22 list of names consisting of five (5) names submitted by each state employee
23 organization that has two thousand (2,000) or more members on state payroll
24 deduction. The advisory committee shall be appointed in January of each year and
25 shall meet quarterly.
- 26 (10) Notwithstanding any other provision of law to the contrary, the policy or policies
27 provided to employees pursuant to this section shall not provide coverage for

1 obtaining or performing an abortion, nor shall any state funds be used for the
2 purpose of obtaining or performing an abortion on behalf of employees or their
3 dependents.

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

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

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

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

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

27 (14) The policy or policies provided to state employees or their dependents pursuant to

1 this section shall provide coverage for obtaining a hearing aid and acquiring hearing
2 aid-related services for insured individuals under eighteen (18) years of age, subject
3 to a cap of one thousand four hundred dollars (\$1,400) every thirty-six (36) months
4 pursuant to KRS 304.17A-132.

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

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

11 ~~(17)~~ If a state employee's residence and place of employment are in the same county,
12 and if the hospital located within that county does not offer surgical services,
13 intensive care services, obstetrical services, level II neonatal services, diagnostic
14 cardiac catheterization services, and magnetic resonance imaging services, the
15 employee may select a plan available in a contiguous county that does provide
16 those services, and the state contribution for the plan shall be the amount available
17 in the county where the plan selected is located.

18 ~~(17)~~(17) If a state employee's residence and place of employment are each located in
19 counties in which the hospitals do not offer surgical services, intensive care
20 services, obstetrical services, level II neonatal services, diagnostic cardiac
21 catheterization services, and magnetic resonance imaging services, the employee
22 may select a plan available in a county contiguous to the county of residence that
23 does provide those services, and the state contribution for the plan shall be the
24 amount available in the county where the plan selected is located.

25 ~~(18)~~(18) The Personnel Cabinet is encouraged to study whether it is fair and reasonable
26 and in the best interests of the state group to allow any carrier bidding to offer
27 health care coverage under this section to submit bids that may vary county by

1 county or by larger geographic areas.

2 ~~(19)~~~~(20)~~ Notwithstanding any other provision of this section, the bid for proposals for
3 health insurance coverage for calendar year 2004 shall include a bid scenario that
4 reflects the statewide rating structure provided in calendar year 2003 and a bid
5 scenario that allows for a regional rating structure that allows carriers to submit bids
6 that may vary by region for a given product offering as described in this subsection:

- 7 (a) The regional rating bid scenario shall not include a request for bid on a
8 statewide option;
- 9 (b) The Personnel Cabinet shall divide the state into geographical regions which
10 shall be the same as the partnership regions designated by the Department for
11 Medicaid Services for purposes of the Kentucky Health Care Partnership
12 Program established pursuant to 907 KAR 1:705;
- 13 (c) The request for proposal shall require a carrier's bid to include every county
14 within the region or regions for which the bid is submitted and include but not
15 be restricted to a preferred provider organization (PPO) option;
- 16 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
17 carrier all of the counties included in its bid within the region. If the Personnel
18 Cabinet deems the bids submitted in accordance with this subsection to be in
19 the best interests of state employees in a region, the cabinet may award the
20 contract for that region to no more than two (2) carriers; and
- 21 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
22 other requirements or criteria in the request for proposal.

23 ~~(20)~~~~(21)~~ Any fully insured health benefit plan or self-insured plan issued or renewed
24 on or after July 12, 2006, to public employees pursuant to this section which
25 provides coverage for services rendered by a physician or osteopath duly licensed
26 under KRS Chapter 311 that are within the scope of practice of an optometrist duly
27 licensed under the provisions of KRS Chapter 320 shall provide the same payment

1 of coverage to optometrists as allowed for those services rendered by physicians or
2 osteopaths.

3 ~~(21)~~~~(22)~~ Any fully insured health benefit plan or self-insured plan issued or renewed to
4 public employees pursuant to this section shall comply with:

- 5 (a) KRS 304.12-237;
- 6 (b) KRS 304.17A-270 and 304.17A-525;
- 7 (c) KRS 304.17A-600 to 304.17A-633;
- 8 (d) KRS 205.593;
- 9 (e) KRS 304.17A-700 to 304.17A-730;
- 10 (f) KRS 304.14-135;
- 11 (g) KRS 304.17A-580 and 304.17A-641;
- 12 (h) KRS 304.99-123;
- 13 (i) KRS 304.17A-138;
- 14 (j) KRS 304.17A-148;
- 15 (k) KRS 304.17A-163 and 304.17A-1631;
- 16 (l) KRS 304.17A-265;
- 17 (m) KRS 304.17A-261;
- 18 (n) KRS 304.17A-262;
- 19 (o) KRS 304.17A-145;
- 20 (p) KRS 304.17A-129;
- 21 (q) KRS 304.17A-133;
- 22 (r) KRS 304.17A-264;~~and~~

23 **(s) Section 1 of this Act; and**

24 ~~(t)~~~~(s)~~ Administrative regulations promulgated pursuant to statutes listed in this
25 subsection.

26 ~~(22)~~~~(23)~~ (a) Any fully insured health benefit plan or self-insured plan issued or
27 renewed to public employees pursuant to this section shall provide a special

1 enrollment period to pregnant women who are eligible for coverage in
2 accordance with the requirements set forth in KRS 304.17-182.

3 (b) The Department of Employee Insurance shall, at or before the time a public
4 employee is initially offered the opportunity to enroll in the plan or coverage,
5 provide the employee a notice of the special enrollment rights under this
6 subsection.

7 ➔Section 8. Sections 1, 2, 6, and 7 of this Act apply to health benefit plans issued
8 or renewed on or after January 1, 2026.

9 ➔Section 9. If the Department for Medicaid Services or the Cabinet for Health
10 and Family Services determines that a state plan amendment, waiver, or any other form
11 of authorization or approval from a federal agency is necessary prior to implementation
12 of Section 3, 4, or 5 of this Act for any reason, including the loss of federal funds, the
13 department or cabinet shall, within 90 days after the effective date of this section, request
14 any necessary state plan amendment, waiver, authorization, or approval, and may only
15 delay full implementation of those provisions for which a state plan amendment, waiver,
16 authorization, or approval was deemed necessary until the state plan amendment, waiver,
17 authorization, or approval is granted or approved.

18 ➔Section 10. The Department for Medicaid Services or the Cabinet for Health
19 and Family Services shall, in accordance with KRS 205.525, provide a copy of any state
20 plan amendment, waiver application, or other request for authorization or approval
21 submitted pursuant to Section 9 of this Act to the Legislative Research Commission for
22 referral to the Interim Joint Committees on Health Services and Appropriations and
23 Revenue and shall provide an update on the status of any application or request submitted
24 pursuant to Section 9 of this Act at the request of the Legislative Research Commission
25 or any committee thereof.

26 ➔Section 11. Sections 1 to 8 of this Act take effect January 1, 2026.