AN ACT relating to pharmacy or pharmacist services.

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

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

(1) As used in this section and Sections 2, 3, 4, 5, and 6 of this Act:

(a) "Health plan" means any policy, contract, or plan that offers or provides coverage in this state for pharmacy or pharmacist services, whether such coverage is by direct payment, reimbursement, or otherwise;

(b) "Insurer":

1. Means any of the following persons or entities that offer or issue a health plan:

a. An insurance company;

b. A health maintenance organization;

c. A limited health service organization;

d. A self-insurer, including a governmental plan, church plan, or multiple employer welfare arrangement, not exempt by federal law from regulation under the insurance laws of this state;

e. A provider-sponsored integrated health delivery network;

f. A self-insured employer-organized association;

g. A nonprofit hospital, medical-surgical, dental, and health service corporation; or

h. Any other third-party payor that is:

i. Authorized to transact health insurance business in this state; or

ii. Not exempt by federal law from regulation under the insurance laws of this state; and

2. Shall include any person or entity that has contracted with a state or

federal agency to provide coverage in this state for pharmacy or pharmacist services;

(c) "Pharmacy benefit manager" has the same meaning as in KRS 304.9-020; and

(d) "Pharmacy or pharmacist services" means any health care procedures, treatments within the scope of practice of a pharmacist, or services provided by a pharmacy or a pharmacist, including the provision of:

1. Prescription drugs, as defined in KRS 315.010; and

2. Home medical equipment, as defined in KRS 309.402.

(2) (a) The provisions of this section and Sections 2, 3, 4, and 5 of this Act shall be subject to all applicable federal law and regulations. To the extent that any provision of this section or Section 2, 3, 4, or 5 of this Act conflicts with an applicable federal law or regulation, the applicable federal law or regulation shall control.

(b) In instances where the enforcement of a provision of this section or Section 2, 3, 4, or 5 of this Act would result in the loss of federal funds that may be available for medical assistance provided under KRS Chapter 205, the provision shall not be enforceable to the extent necessary to qualify for receipt of the federal funds.

(c) The Cabinet for Health and Family Services, or any of its departments, shall take any steps necessary to effectuate the provisions of this section and Sections 2, 3, 4, and 5 of this Act as applied to the provision of services under KRS Chapter 205, including but not limited to:

1. Requesting an amendment to the State Medicaid Plan;

2. Filing an application for a waiver or waiver amendment; or

3. Making any other submissions necessary to obtain approval or authorization for the Department for Medicaid Services and any

managed care organization contracted with the department to provide services under KRS Chapter 205 to comply with the provisions of this section and Sections 2, 3, 4, and 5 of this Act.

➔Section 2. KRS 304.17A-164 is amended to read as follows:

Except as provided in Section 1 of this Act:

(1) As used in this section:

(a) "***Cost-sharing***~~[Cost sharing]~~" means the cost to ***a patient covered***~~[an individual insured]~~ under a health~~[benefit]~~ plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan;

(b) ~~["Insurer" includes:~~

~~1. An insurer offering a health benefit plan providing coverage for pharmacy benefits; or~~

~~2. Any other administrator of pharmacy benefits under a health benefit plan;~~

~~(c)]~~"Pharmacy" includes:

1. A pharmacy, as defined in KRS Chapter 315;

2. A pharmacist, as defined in KRS Chapter 315; ***and***~~[or]~~

3. Any employee of a pharmacy or pharmacist; and

(c)~~[(d)]~~ ***"Pharmacy affiliate" means any pharmacy in which:***

1. The insurer, pharmacy benefit manager, or other administrator of pharmacy benefits, either directly or indirectly through one or more intermediaries:

a. Has an investment or ownership interest; or

b. Shares common ownership with the pharmacy; or

2. An investor or ownership interest holder of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits, either

directly or indirectly through one or more intermediaries, has an investment or ownership interest~~["Pharmacy benefit manager" has the same meaning as in KRS 304.17A-161]~~.

(2) An insurer***, a***~~[issuing or renewing a health benefit plan on or after January 1, 2019, or]~~ pharmacy benefit manager***, or any other administrator of pharmacy benefits*** shall not:

(a) Require ***a patient covered under a health plan issued or renewed on or after the effective date of this Act***~~[an insured purchasing a prescription drug]~~ to***:***

1. Pay a cost-sharing amount ***for pharmacy or pharmacist services that is*** greater than the amount the ***patient***~~[insured]~~ would pay for the ***services***~~[drug]~~ if he or she were to purchase the ***services***~~[drug]~~ without coverage under ***the***~~[a health benefit]~~ plan;

2. Pay a cost-sharing amount for pharmacy or pharmacist services that is greater than what was paid by or charged to the patient for the services at the point of sale;

3. Use a mail-order pharmaceutical distributor, including a mail-order pharmacy; or

4. Pay cost-sharing for pharmacy or pharmacist services received from a nonaffiliated pharmacy that is greater than what would otherwise be imposed if the patient used a pharmacy affiliate or a mail-order pharmaceutical distributor, including a mail-order pharmacy;

(b) Prohibit a pharmacy from discussing any information under subsection (3) of this section; ***or***~~[and]~~

(c) Impose a penalty on a pharmacy for complying with this section.

(3) A pharmacist shall have the right to provide ***a patient***~~[an insured]~~ information regarding the applicable limitations on his or her cost-sharing pursuant to this section~~[for a prescription drug]~~.

(4) Any amount paid by ***a patient***~~[an insured]~~ under subsection (2)(a)***1.*** of this section shall be attributable toward any annual out-of-pocket maximums under the ***patient's***~~[insured's]~~ health~~[benefit]~~ plan.

➔SECTION 3. A NEW SECTION OF KRS 304.17A-165 TO 304.17A-166 IS CREATED TO READ AS FOLLOWS:

Except as provided in Section 1 of this Act:

(1) (a) All insurers, pharmacy benefit managers, and other administrators of pharmacy benefits that utilize a pharmacy network shall ensure that the network is reasonably adequate and accessible for the provision of pharmacy or pharmacist services under health plans issued or renewed on or after the effective date of this Act.

(b) Each pharmacy network shall offer:

1. An adequate number of accessible pharmacies that are not mail-order pharmacies; and

2. A provider network that meets the accessibility requirements set forth in subsection (1)(f)3. of Section 11 of this Act.

(2) (a) All insurers, pharmacy benefit managers conducting business in this state, and other administrators of pharmacy benefits in this state shall file with the commissioner an annual report in the manner and form prescribed by the commissioner describing the pharmacy networks of each insurer, pharmacy benefit manager, and other administrator of pharmacy benefits.

(b) The commissioner shall review each pharmacy network to ensure that the network is reasonably adequate and accessible as required by subsection (1) of this section.

(3) The commissioner may review and approve the compensation program of insurers, pharmacy benefit managers conducting business in this state, and other administrators of pharmacy benefits in this state to ensure that:

(a) Reimbursement for pharmacy or pharmacist services by insurers, pharmacy benefit managers, and other administrators of pharmacy benefits is fair and reasonable; and

(b) The programs do not impede the maintenance of reasonably adequate and accessible pharmacy networks.

(4) All information and data acquired by the department under subsections (2) and (3) of this section shall be considered proprietary and confidential and shall not be subject to disclosure under KRS 61.870 to 61.884.

➔SECTION 4. A NEW SECTION OF KRS 304.17A-165 TO 304.17A-166 IS CREATED TO READ AS FOLLOWS:

Except as provided in Section 1 of this Act:

(1) As used in this section:

(a) "Actual overpayment" means the portion of any amount paid for pharmacy or pharmacist services that:

1. Is duplicative because the pharmacy or pharmacist has already been paid for the services; or

2. Were not rendered in accordance with the prescriber's order; and

(b) "Pharmacy affiliate" has the same meaning as in Section 2 of this Act.

(2) Every contract issued, delivered, entered, renewed, extended, or amended on or after the effective date of this Act between a pharmacy or pharmacist and the following for the provision of pharmacy or pharmacist services in this state, either directly or through a pharmacy services administration organization, shall comply with subsections (3) and (4) of this section:

(a) An insurer;

(b) A pharmacy benefit manager; or

(c) Any other administrator of pharmacy benefits.

(3) A contract referenced in subsection (2) of this section shall:

(a) Outline the terms and conditions for the provision of pharmacy and pharmacist services;

(b) Establish procedures for changing the contract, which shall comply with KRS 304.17A-235. For purposes of implementing this paragraph, any changes to procedures set forth in the contract for dispute resolution, verifying drugs included on a formulary, or contract termination shall be considered material;

(c) Provide the pharmacy or pharmacist:

1. A thirty (30) day right to cure any violations of the terms and conditions of the contract prior to termination or nonrenewal of the contract on the basis of those violations;

2. At least ninety (90) days' prior written notice of a nonrenewal of the contract, sent in accordance with the notice required for proposed material changes under KRS 304.17A-235, which shall include the following:

a. The proposed effective date of the nonrenewal;

b. The name, business address, telephone number, and electronic mail address of a representative of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits to discuss the proposed nonrenewal; and

c. An opportunity for a meeting using real-time communication to discuss the proposed nonrenewal; and

3. Unless otherwise required to comply with state or federal law, at least thirty (30) days' prior written notice of any notices to patients covered under a health plan that the pharmacy has been or will be removed from the plan's provider network; and

(d) Notwithstanding Sections 8, 9, and 10 of this Act, prohibit the insurer,

pharmacy benefit manager, or other administrator of pharmacy benefits from doing the following:

1. Reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement. This prohibition shall include, without limitation, the use of generic effective rates, dispensing effective rates, brand effective rates, direct and indirect remuneration fees, or any other mechanism that reduces or aggregately reduces payment for pharmacy or pharmacist services;

2. Retroactively denying a claim or seeking any refunds or recoupments, in whole or in part, from the pharmacy or pharmacist after adjudication of a claim for pharmacy or pharmacist services, including claims for the cost of a medication or dispensed product and claims for services that are deemed ineligible for coverage, unless one or more of the following occurred:

a. The original claim was submitted fraudulently; or

b. The pharmacy received an actual overpayment;

3. Unless reviewed and approved by the commissioner, assessing any fees against the pharmacy or pharmacist that are related to a claim for pharmacy or pharmacist services, including, without limitation, a fee for:

a. The receipt and processing of a claim;

b. The development or management of claims processing services in a pharmacy network; or

c. Participation in a pharmacy network;

4. Reimbursing a pharmacy or pharmacist for a prescription drug or other service in an amount, which shall be calculated on a per-unit

basis using the same generic product identifier or generic code number, less than the amount the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits reimburses a pharmacy affiliate for providing the same prescription drug or other service; and

5. Reimbursing a pharmacy or pharmacist for the ingredient drug product component of a pharmacy or pharmacist service that is less than the national average drug acquisition cost or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost.

(4) A contract referenced in subsection (2) of this section shall not:

(a) Be a contract of adhesion;

(b) Release the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits from the obligation to make any payments owed to the pharmacy or pharmacist for services rendered prior to the termination of a pharmacy from a pharmacy network;

(c) Require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to Kentucky Board of Pharmacy standards or requirements;

(d) Require a pharmacy or pharmacist to dispense a prescription drug to a patient, unless otherwise required by state or federal law;

(e) Designate a prescription drug as a "specialty drug" unless the drug is a limited distribution prescription drug that:

1. Requires special handling; and

2. Is not commonly carried at retail pharmacies or oncology clinics or practices;

(f) Deny, limit, or terminate a pharmacy's contract based on the employment status of any employee who has an active license to dispense, despite

probation status, with the Kentucky Board of Pharmacy; or

(g) Prohibit, restrict, or limit the disclosure of information to the commissioner, a state or federal law enforcement agency, or a state or federal regulatory agency.

(5) An insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits shall not:

(a) Cause or knowingly permit the use, in this state, of any advertisement, promotion, solicitation, representation, proposal, or offer relating to the following that is untrue, deceptive, or misleading:

1. Pharmacy benefits or services; or

2. A pharmacy contract or reimbursement for the provision of pharmacy or pharmacist services;

(b) Discriminate, which discrimination may include denying a pharmacy the opportunity to participate in a pharmacy network at preferred participation status, against any pharmacy or pharmacist that is:

1. Located within the geographic coverage area of the health plan; and

2. Willing to meet reasonable terms and conditions established by the insurer, pharmacy benefit manager, or other administrator for network participation, including obtaining preferred participation status;

(c) Reject offers or applications, including any pre-applications, to contract for the provision of pharmacy or pharmacist services in this state made by a pharmacy or pharmacist that, if required, has been credentialed unless the following notice is provided, by telephone, to the pharmacy or pharmacist at least fifteen (15) calendar days prior to the rejection:

1. Notice that the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits intends to reject the offer or

application; and

2. The reason or reasons why the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits intends to reject the offer or application;

(d) Fail to issue the following in response to a pharmacy or pharmacist's offer or application, including any pre-applications, to contract for the provision of pharmacy or pharmacist services in this state within thirty (30) calendar days of the offer or application, or, if credentialing is required, the date the pharmacy or pharmacist was credentialed, whichever is later:

1. An acceptance or rejection of the offer or application; and

2. If an acceptance is issued, any applicable provider numbers; or

(e) Discriminate or otherwise retaliate against a pharmacy or pharmacist that makes a disclosure referenced in subsection (4)(g) of this section.

➔SECTION 5. A NEW SECTION OF KRS 304.17A-165 TO 304.17A-166 IS CREATED TO READ AS FOLLOWS:

Except as provided in Section 1 of this Act:

(1) As used in this section:

(a) 1. "Rebate" means a discount, price concession, or payment that is:

a. Based on utilization of a prescription drug; and

b. Paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager or other administrator of pharmacy benefits, pharmacy services administration organization, or a pharmacy after a claim has been processed and paid at a pharmacy.

2. Rebate includes without limitation incentives, disbursements, and reasonable estimates of a volume-based discount; and

(b) "Spread pricing" means a pharmacy benefit manager or other

administrator of pharmacy benefits charging or claiming an amount from an insurer for payment of pharmacy or pharmacist services, including payment for a prescription drug, that is different than the amount the pharmacy benefit manager or other administrator pays to the pharmacist or pharmacy that provided the services.

(2) An insurer shall:

(a) Ensure that all contracts with a pharmacy benefit manager or other administrator of pharmacy benefits that are issued, delivered, entered, renewed, extended, or amended on or after the effective date of this Act provide that the pharmacy benefit manager or administrator shall:

1. Act as the insurer's agent;

2. Owe a fiduciary duty to the insurer; and

3. Comply with all requirements of this chapter; and

(b) Monitor the activities carried out in this state on behalf of the insurer by a pharmacy benefit manager or other administrator of pharmacy benefits to ensure compliance with the requirements of this chapter.

(3) A pharmacy benefit manager or other administrator of pharmacy benefits shall not engage or participate in spread pricing in this state under any contract issued, delivered, entered, renewed, extended, or amended on or after the effective date of this Act.

(4) (a) A pharmacy benefit manager or other administrator of pharmacy benefits shall report to the commissioner, on a quarterly basis, for each insurer, except insurers contracted to provide Medicaid benefits under KRS Chapter 205:

1. The aggregate amount of rebates received by the pharmacy benefit manager or other administrator;

2. The aggregate amount of rebates distributed to the insurer;

3. The aggregate amount of rebates passed on to the insureds of the insurer at the point of sale that reduced the insured's applicable deductible, copayment, coinsurance, or other cost-sharing amount;

4. The individual and aggregate amount paid by the insurer to the pharmacy benefit manager or other administrator for pharmacy or pharmacist services, which shall be itemized by pharmacy, by product, and by goods and services; and

5. The individual and aggregate amount a pharmacy benefit manager or other administrator paid for pharmacy or pharmacist services, which shall be itemized by pharmacy, by product, and by goods and services.

(b) All information and data acquired by the department under this subsection shall be considered proprietary and confidential and shall not be subject to disclosure under KRS 61.870 to 61.884, except the department may publicly disclose aggregated information not descriptive of any readily identifiable person or entity.

(5) In order to effectuate, or as an aid to the effectuation of, any provision of this chapter relating to pharmacy benefit managers or other administrators of pharmacy benefits, the commissioner may promulgate administrative regulations establishing prohibited practices of pharmacy benefit managers or other administrators of pharmacy benefits that provide claims processing services or other pharmacy benefit management services for health plans.

➔SECTION 6. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) There is hereby created and established a Pharmacy Benefits Management Advisory Council whose duties shall be to review and make recommendations to the commissioner as to the implementation, interpretation, and enforcement of insurance laws relating to:

(a) Pharmacy or pharmacist services provided to persons covered under a health plan; and

(b) Pharmacy benefit managers.

(2) The advisory council shall consist of six (6) members, which shall include the commissioner as a nonvoting member. The commissioner shall serve as chair of the advisory council. The remaining members shall serve two (2) year terms, be appointed by the Governor, with the advice of the commissioner, and shall be constituted as follows:

(a) Three (3) members shall be pharmacists, at least two (2) of whom shall be affiliated with an independent pharmacy. For the purposes of this paragraph, an independent pharmacy is a pharmacy:

1. In which a pharmacy benefit manager does not have an ownership interest, either directly or through an affiliate or subsidiary; and

2. That does not have an ownership interest, either directly or through an affiliate or subsidiary, in a pharmacy benefit manager;

(b) One (1) member shall be a pharmacy benefit manager licensed by the commissioner; and

(c) One (1) member shall be an insurer.

(3) The first meeting of the council shall take place within thirty (30) days of the appointment of all the members.

(4) The council shall meet at least quarterly, and may meet more frequently upon the call of the commissioner. A majority of the members shall constitute a quorum. Recommendations of the council shall require a majority of the members present, which shall include participation through distance communication technology, and eligible to vote.

(5) The advisory council shall be a budgetary unit of the department, which shall pay all of the advisory council's necessary operating expenses and shall furnish all

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

(6) Members of the committee, except the commissioner, shall receive no compensation for service, but shall receive actual and necessary travel expenses associated with attending meetings, which shall be in accordance with state regulations relating to travel reimbursement.

➔Section 7. KRS 304.17A-005 is amended to read as follows:

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

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

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

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

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Basic health benefit plan" means any plan offered to an individual, a small group, or employer-organized association that limits coverage to physician, pharmacy, home health, preventive, emergency, and inpatient and outpatient hospital services in accordance with the requirements of this subtitle. If vision or eye services are

offered, these services may be provided by an ophthalmologist or optometrist. Chiropractic benefits may be offered by providers licensed pursuant to KRS Chapter 312;

(5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(7) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(8) "Creditable coverage":

(a) Means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;

2. Health insurance coverage;

3. Part A or Part B of Title XVIII of the Social Security Act;

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

5. Chapter 55 of Title 10, United States Code, including medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Chapter 55 of Title 10, United States Code, "uniformed services" means the Armed Forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service;

6. A medical care program of the Indian Health Service or of a tribal

organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5, United States Code, such as the Federal Employees Health Benefit Program;

9. A public health plan as established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

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

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

(b) Does not include coverage consisting solely of coverage of excepted benefits as defined in this section;

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

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

(11) "Eligible individual" means an individual:

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

period, during all of which the individual was not covered under any creditable coverage;

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

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

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

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

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

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

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

(c) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare benefit plan under guidance issued by the United States Department of Labor prior to the issuance of 29 C.F.R. sec. 2510.3-5, and for which the entity's health insurance decisions are made by a board or committee, the majority of

which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation; and

(d) Any entity or association of employers, which has been actively in existence for at least two (2) years, formed under the Employee Retirement Income Security Act, 29 U.S.C. secs. 1001 et seq., to provide an employee welfare benefit plan, whose members consist of employers or a group of employers that satisfy the requirements of 29 C.F.R. sec. 2510.3-5.

Except as provided in KRS 304.17A-0954, 304.17A-200, and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in this section, an employer-organized association shall not be treated as an association, small group, or large group under this subtitle, except that an employer-organized association as defined under paragraph (c) or (d) of this subsection shall be treated as a large group under this subtitle;

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

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

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

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

(c) Liability insurance, including general liability insurance and automobile

liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

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

(i) Limited scope dental or vision benefits;

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

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

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

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan; and

(q) Health flexible spending arrangements;

(15) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(16) "Group health plan" means a plan, including a self-insured plan, of or contributed to by an employer, including a self-employed person, or employee organization, to provide health care directly or otherwise to the employees, former employees, the

employer, or others associated or formerly associated with the employer in a business relationship, or their families;

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

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

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

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

(a) Is not an eligible individual;

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

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

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

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

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

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

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;
2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or
3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

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

(22) "Health benefit plan":

(a) Shall include any:

1. Hospital or medical expense policy or certificate;
2. Nonprofit hospital, medical-surgical, and health service corporation contract or certificate;
3. Provider sponsored integrated health delivery network;
4. Self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA;
5. Self-insured governmental plan or church plan;
6. Health maintenance organization contract, except contracts to provide Medicaid benefits under KRS Chapter 205; or
7. Health benefit plan that affects the rights of a Kentucky insured and

bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky; and

(b) Does not include:

1. Policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement, long-term care, Medicare supplement, specified disease, or vision care;
2. Coverage issued as a supplement to liability insurance;
3. Insurance arising out of a workers' compensation or similar law;
4. Automobile medical-payment insurance;
5. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
6. Short-term limited-duration coverage;
7. Student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure;
8. Medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract;
9. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code;
10. Limited health service benefit plans;
11. Direct primary care agreements established under KRS 311.6201, 311.6202, 314.198, and 314.199; or
12. Coverage provided under KRS Chapter 205;

(23) "Health care provider" or "provider" means any:

(a) Advanced practice registered nurse licensed under KRS Chapter 314;

(b) Chiropractor licensed under KRS Chapter 312;

(c) Dentist licensed under KRS Chapter 313;

(d) Facility or service required to be licensed under KRS Chapter 216B;

(e) Home medical equipment and services provider licensed under KRS Chapter 309;

(f) Optometrist licensed under KRS Chapter 320;

(g) ***Pharmacy or*** pharmacist ***permitted or*** licensed under KRS Chapter 315;

(h) Physician, osteopath, or podiatrist licensed under KRS Chapter 311;

(i) Physician assistant regulated under KRS Chapter 311; and

(j) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(24) (a) "Health care service" means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

(b) Health care service includes the provision of prescription drugs, as defined in KRS 315.010, and home medical equipment, as defined in KRS 309.402;

(25) "Health facility" or "facility" has the same meaning as in KRS 216B.015;

(26) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is

considered to be high-cost by using:

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

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

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

(28) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan. The individual market includes an association plan that is not employer-related, issued to individuals on an individually underwritten basis, other than an employer-organized association or a bona fide association;

(29) "Insurer" means any insurance company; health maintenance organization; self-insurer, including a governmental plan, church plan, or multiple employer welfare

arrangement, not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

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

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

(32) "Large group" means:

(a) An employer with fifty-one (51) or more employees;

(b) An affiliated group with fifty-one (51) or more eligible members; or

(c) A fully insured employer-organized association as defined in subsection (12)(c) or (d) of this section that:

1. Covers at least fifty-one (51) employee members; and

2. Is registered with the department pursuant to administrative regulations promulgated by the commissioner;

(33) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(34) "Market segment" means the portion of the market covering one (1) of the

following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(35) "Medically necessary health care services" means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(a) In accordance with generally accepted standards of medical practice; and

(b) Clinically appropriate in terms of type, frequency, extent, and duration;

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

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

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

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

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

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

(42) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

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

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

(45) "Small group" means:

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

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

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

(47) "Telehealth":

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

(b) Shall not include the delivery of services through electronic mail, text chat,

facsimile, or standard audio-only telephone call; and

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

➔Section 8. KRS 304.17A-708 is amended to read as follows:

(1) An insurer shall not require a provider to appeal errors in payment where the insurer has not paid the claim according to the contracted rate. Miscalculations in payments made by the insurer shall be corrected and paid within thirty (30) calendar days upon the insurer's receipt of documentation from the provider verifying the error.

(2) An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24) months after the date that the provider received payment for the claim from the insurer.

(3) (a) Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider.

(b) An insurer that retroactively denies reimbursement to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial.

(c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) If an insurer retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the provider shall have twelve (12) months from the date that the provider received notice of the denial, unless the insurer that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the insurer, the

medical assistance program, or the Medicare program responsible for payment.

(e) Notwithstanding the provisions of this subsection, an insurer shall not request a refund or recoup funds from a pharmacy or pharmacist in violation of Section 4 of this Act.

➔Section 9. KRS 304.17A-712 is amended to read as follows:

Except as provided in Section 4 of this Act, if an insurer determines that payment was made for services rendered to an individual who was not eligible for coverage or that payment was made for services not covered by a covered person's health benefit plan, the insurer shall give written notice to the provider and:

(1) Request a refund from the provider; or

(2) Make a recoupment of the overpayment from the provider in accordance with KRS 304.17A-714.

➔Section 10. KRS 304.17A-714 is amended to read as follows:

Except as provided in Section 4 of this Act:

(1) Except for overpayments which are a result of an error in the payment rate or method, an insurer that determines that a provider was overpaid shall, within twenty-four (24) months from the date that the insurer paid the claim, provide written or electronic notice to the provider of the amount of the overpayment, the covered person's name, patient identification number, date of service to which the overpayment applies, insurer reference number for the claim, and the basis for determining that an overpayment exists. Electronic notice includes e-mail or facsimile where the provider agreed in advance in writing to receive such notices. The insurer shall either:

(a) Request a refund from the provider; or

(b) Indicate on the notice that, within thirty (30) calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not

receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.

(2) If a provider disagrees with the amount of the overpayment, the provider shall within thirty (30) calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer.

(3) If a provider files a dispute in accordance with subsection (2) of this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in subsection (2) of this section, the insurer may recoup the amount due from future payments.

(4) All disputes submitted by providers pursuant to subsection (2) of this section shall be processed in accordance and completed within thirty (30) days with the insurer's provider appeals process.

(5) An insurer may recover an overpayment resulting from an error in the payment rate or method by requesting a refund from the provider or making a recoupment of the overpayment from the provider, subject to the provisions of subsection (6) of this section. A provider may dispute such recoupment in accordance with the provisions contained in KRS 304.17A-708.

(6) If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, and at the actual time of recoupment give the provider written or electronic documentation that specifies:

(a) The amount of the recoupment;

(b) The covered person's name to whom the recoupment applies;

(c) Patient identification number; and

(d) Date of service.

➔Section 11. KRS 304.17A-515 is amended to read as follows:

(1) ***An insurer offering*** a managed care plan shall arrange for a sufficient number and type of primary care providers**,**~~[and]~~ specialists***, and pharmacy services*** throughout the plan's service area to meet the needs of enrollees. Each ***insurer***~~[managed care plan]~~ shall demonstrate that it offers:

(a) An adequate number of accessible acute care hospital services, where physically available;

(b) An adequate number of accessible primary care providers, including family practice and general practice physicians, internists, obstetricians/gynecologists, and pediatricians, where available;

(c) An adequate number of accessible specialists and subspecialists, and when the specialist needed for a specific condition is not represented on the plan's list of participating specialists, enrollees have access to nonparticipating health care providers with prior plan approval;

(d) ***An adequate number of accessible pharmacies that are not mail-order pharmacies;***

(e) The availability of specialty services; and

(f)~~[(e)]~~ A provider network that meets the following accessibility requirements:

1. For urban areas, a provider network that is available to all persons enrolled in the plan within thirty (30) miles or thirty (30) minutes of each ***enrollee's***~~[person's]~~ place of residence or work, to the extent that services are available;~~[or]~~

2. For areas other than urban areas, a provider network that makes available primary care physician services~~[,]~~ ***and*** hospital services~~[, and pharmacy services]~~ within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent those services

are available. All other ***services, except pharmacy services,*** ~~[providers]~~ shall be available to all persons enrolled in the plan within fifty (50) minutes or fifty (50) miles of each enrollee's place of residence or work, to the extent those services are available***; and***

3. For pharmacy services, a provider network that provides convenient access to pharmacies that are not mail-order pharmacies within a reasonable distance from the enrollee's residence, but in no event shall the distance be more than thirty (30) minutes or thirty (30) miles from each enrollee's residence, to the extent that services are available.

(2) ***An insurer offering*** a managed care plan shall provide***:***

(a) Telephone access to the plan during business hours to ensure plan approval of nonemergency care***; and*** ~~[. A managed care plan shall provide]~~

(b) Adequate information to enrollees regarding access to urgent and emergency care.

(3) ***An insurer offering*** a managed care plan shall establish reasonable standards for waiting times to obtain appointments, except as provided for emergency care.

➔SECTION 12. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

The provisions of Sections 1, 2, 3, 4, 5, and 6 of this Act shall apply to limited health service benefit plans, including limited health service contracts as defined in KRS 304.38A-010.

➔Section 13. KRS 304.17C-040 is amended to read as follows:

Except as provided in Section 3 of this Act, an insurer that offers a limited health service benefit plan that utilizes a provider network shall have a provider network that is available to all persons enrolled in the plan within thirty (30) minutes or thirty (30) miles of each enrollee's place of residence or work, to the extent available.

➔SECTION 14. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

A limited health service organization shall comply with Sections 1, 2, 3, 4, and 5 of this Act.

➔Section 15. KRS 205.522 is amended to read as follows:

The Department for Medicaid Services and any managed care organization contracted to provide Medicaid benefits pursuant to this chapter shall comply with the ***following*** provisions of ***Subtitle 17A of KRS Chapter 304, as applicable:***

(1) KRS 304.17A-167***;*** ~~[,]~~

(2) KRS 304.17A-235***;*** ~~[,]~~

(3) KRS 304.17A-515***;*** ~~[,]~~

(4) KRS 304.17A-580***;*** ~~[,]~~

(5) KRS 304.17A-600, 304.17A-603, ***and*** 304.17A-607***;*** ~~[, and]~~

(6) KRS 304.17A-740 to 304.17A-743~~[, as applicable]~~***; and***

(7) Sections 1, 2, 3, 4, and 5 of this Act.

➔Section 16. KRS 205.532 is amended to read as follows:

(1) As used in KRS 205.532 to 205.536:

(a) "Clean application" means:

1. For credentialing purposes, a credentialing application submitted by a provider to a credentialing verification organization that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation; and

c. Is consistent with the requirements for the National Committee for Quality Assurance requirements; or

2. For enrollment purposes, an enrollment application submitted by a provider to the department that:

a. Is complete and correct;

b. Does not lack any required substantiating documentation;

c. Complies with all provider screening requirements pursuant to 42 C.F.R. pt. 455; and

d. Is on behalf of a provider who does not have accounts receivable with the department;

(b) "Credentialing application date" means the date that a credentialing verification organization receives a clean application from a provider;

(c) "Credentialing verification organization" means an organization that gathers data and verifies the credentials of providers in a manner consistent with federal and state laws and the requirements of the National Committee for Quality Assurance. "Credentialing verification organization" is limited to the following:

1. An organization designated by the department pursuant to subsection (3)(a) of this section; and

2. Any bona fide, nonprofit, statewide, health care provider trade association, organized under the laws of Kentucky, that has an existing contract with the department or a managed care organization, as of July 1, 2018, to perform credentialing verification activities;

(d) "Department" means the Department for Medicaid Services;

(e) "Medicaid managed care organization" or "managed care organization" means an entity for which the department has contracted to serve as a managed care organization as defined in 42 C.F.R. sec. 438.2;

(f) "Provider" has the same meaning as in KRS 304.17A-700; and

(g) "Request for proposals" has the same meaning as in KRS 45A.070.

(2) On and after January 1, 2019, every contract entered into or renewed for the delivery of Medicaid services by a managed care organization shall be in compliance with KRS 205.522, 205.532 to 205.536, and 304.17A-515.

(3) (a) Through a request for proposals, the department shall designate a single organization as a credentialing verification organization to verify the credentials of providers on behalf of all managed care organizations.

(b) Following the department's designation pursuant to this subsection, the contract between the department and the designated credentialing verification organization shall be submitted to the Government Contract Review Committee of the Legislative Research Commission for comment and review.

(c) A credentialing verification organization, designated by the department, shall be reimbursed on a per provider credentialing basis by the department. The reimbursements shall be offset or deducted equally from each Medicaid managed care organizations capitation payments.

(d) The department shall enroll and screen providers in accordance with 42 C.F.R. pt. 455 and applicable state and federal law.

(e) Each provider seeking to be enrolled and screened with the department shall make application via electronic means as determined by the department.

(f) Pursuant to federal law, all providers seeking to participate in the Medicaid program with a managed care organization shall be enrolled as a provider with the department.

(g) Each provider seeking to be credentialed with a Medicaid managed care organization shall submit a single credentialing application to the designated credentialing verification organization, or to an organization meeting the requirements of subsection (1)(c)2. of this section, if applicable. The credentialing verification organization shall:

1. Gather all necessary documentation from each provider;
2. Within five (5) days of receipt of a credentialing application, notify the provider in writing if the application is complete;
3. Review an application for any misstatement of fact or lack of

substantiating documentation;

4. Credential and provide verified credentialing information electronically to the department and to each managed care organization as requested by the provider within thirty (30) calendar days of receipt of a clean application; and

5. Conduct reevaluations of provider documentation when required pursuant to state or federal law or for the provider to maintain participation status with a managed care organization.

(4) (a) The department shall enroll a provider within sixty (60) calendar days of receipt of a clean provider enrollment application. The date of enrollment shall be the date that the provider's clean application was initially received by the department. The time limits established in this section shall be tolled or paused by a delay caused by an external entity. Tolling events include but are not limited to the screening requirements contained in 42 C.F.R. pt. 455 and searches of federal databases maintained by entities such as the United States Centers for Medicare and Medicaid Services.

(b) A Medicaid managed care organization shall:

1. ***Issue an acceptance or rejection to***~~[determine whether it will]~~ contract with the provider within thirty (30) calendar days of receipt of the verified credentialing information from the credentialing verification organization; and

2. a. Within ten (10) days of an executed contract, ensure that any internal processing systems of the managed care organization have been updated to include:

i. The accepted provider contract; and

ii. The provider as a participating provider.

b. In the event that the loading and configuration of a contract with a

provider will take longer than ten (10) days, the managed care organization may take an additional fifteen (15) days if it has notified the provider of the need for additional time.

(5) (a) Nothing in this section requires a Medicaid managed care organization to contract with a provider if the managed care organization and the provider do not agree on the terms and conditions for participation.

(b) Nothing in this section shall prohibit a provider and a managed care organization from negotiating the terms of a contract prior to the completion of the department's enrollment and screening process.

(6) (a) For the purpose of reimbursement of claims, once a provider has met the terms and conditions for credentialing and enrollment, the provider's credentialing application date shall be the date from which the provider's claims become eligible for payment.

(b) A Medicaid managed care organization shall not require a provider to appeal or resubmit any clean claim submitted during the time period between the provider's credentialing application date and a managed care organization's completion of its credentialing process.

(c) Nothing in this section shall limit the department's authority to establish criteria that allow a provider's claims to become eligible for payment in the event of lifesaving or life-preserving medical treatment, such as, for an illustrative but not exclusive example, an organ transplant.

(7) Nothing in this section shall prohibit a university hospital, as defined in KRS 205.639, from performing the activities of a credentialing verification organization for its employed physicians, residents, and mid-level practitioners where such activities are delineated in the hospital's contract with a Medicaid managed care organization. The provisions of subsections (3), (4), (5), and (6) of this section with regard to payment and timely action on a credentialing application shall apply to a

credentialing application that has been verified through a university hospital pursuant to this subsection.

(8) To promote seamless integration of licensure information, the relevant provider licensing boards in Kentucky are encouraged to forward and provide licensure information electronically to the department and any credentialing verification organization.

(9) Nothing in this section shall be construed to permit acts that are prohibited under Sections 2, 3, 4, or 5 of this Act.

➔Section 17. KRS 205.647 is amended to read as follows:

(1) As used in this section***:*** ~~[,]~~

(a) "Department" means Department for Medicaid Services; and

(b) "Pharmacy benefit manager" has the same meaning as in KRS 304.9-020.

(2) A pharmacy benefit manager contracted ***directly with the cabinet or department, or*** with a managed care organization ***, to administer*** ~~[that provides]~~ Medicaid benefits pursuant to this chapter shall comply with the provisions of ***KRS Chapter 304, to the extent applicable and not in conflict with the expressed provisions of this chapter*** ~~[this section and KRS 304.9-053, 304.9-054, 304.9-055, and 304.17A-162]~~.

(3) KRS 304.17A-162(10), (11), (12), and (13) shall not apply to a pharmacy benefit manager contracted directly with the cabinet ***or department*** to provide Medicaid benefits.

(4) ***A managed care organization contracted to provide Medicaid benefits, a pharmacy benefit manager, or any subcontractor of same shall not require a pharmacy, a group of pharmacies, or a pharmacy services administration organization to participate with the Medicaid program, business, or network of the managed care organization, pharmacy benefit manager, or subcontractor in order to participate with the non-Medicaid programs, businesses, or pharmacy networks of the managed care organization, pharmacy benefit manager,***

subcontractor, or controlling entity, including but not limited to commercial insurance pharmacy networks and other government or government-related pharmacy networks, such as Medicare.

(5) A pharmacy benefit manager contracting ***directly with the cabinet or department, or*** with a managed care organization**,** to administer Medicaid benefits shall provide the following information to the department~~[for Medicaid Services]~~ no later than August 15 ***of***~~[, 2018, and for]~~ each year~~[thereafter]~~ that the pharmacy benefit manager is contracted ***directly with the cabinet or department, or*** with a managed care organization**,** to administer Medicaid benefits***, and at any time upon the department's request***:

(a) The total Medicaid dollars paid to the pharmacy benefit manager by ***the cabinet or department, or by*** a managed care organization**,** and the total amount of Medicaid dollars paid to the pharmacy benefit manager by ***the cabinet or department, or by*** a managed care organization**,** which were not subsequently paid to a pharmacy licensed in Kentucky;

(b) 1. The average reimbursement, by drug ingredient cost, dispensing fee, and any other fee paid by a pharmacy benefit manager to licensed pharmacies with which the pharmacy benefit manager shares common ownership, management, or control; or which are owned, managed, or controlled by any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company; or which share any common members on the board of directors; or which share managers in common.

2. For the purposes of this subsection, "average reimbursement" means a statistical methodology selected by the department~~[for Medicaid Services]~~ via any administrative regulations promulgated pursuant to

this section which shall include, at a minimum, the median and mean;

(c) The average reimbursement, by drug ingredient cost, dispensing fee, and any other fee, paid by a pharmacy benefit manager to pharmacies licensed in Kentucky which operate more than ten (10) locations;

(d) The average reimbursement by drug ingredient cost, dispensing fee, and any other fee, paid by a pharmacy benefit manager to pharmacies licensed in Kentucky which operate ten (10) or fewer locations;

(e) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky**, *or the pharmacy's contracting entity, including a pharmacy services administration organization,*** with which the pharmacy benefit manager shares common ownership, management, or control; or which are owned, managed, or controlled by any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company; or which share any common members on the board of directors; or which share managers in common;

(f) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky which operate more than ten (10) locations**, *or the pharmacy's contracting entity, including a pharmacy services administration organization***;

(g) Any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in Kentucky which operate ten (10) or fewer locations**, *or the pharmacy's contracting entity, including a pharmacy services administration organization***;~~[and]~~

(h) ***Any money recovered after the point of sale by a pharmacy benefit manager, including an entity that is contracted or controlled by a pharmacy***

benefit manager, from a pharmacy licensed in Kentucky or the pharmacy's contracting entity, including a pharmacy services administration organization, via:

1. Clawback;

2. The establishment of performance metrics for a pharmacy's business;

3. Any direct or indirect fees, which shall include transmission fees, network fees, network variable rates, pharmacy performance metrics, out-of-network fees, performance clawback fees, generic effective rate fees, brand effective rate fees, or any other kind of assessment or charge; or

4. Any other formulaic money or asset recovery requirement based on sales, sale volume, prices, inventory, or volume of drugs ordered or requested by the pharmacy or the pharmacy's contracted pharmacy services administration organization;

(i) 1. Any requested claims data or claims-level data held, collected, or processed by the pharmacy benefit manager or any contracted entity.

2. Any claims data or claims-level data provided by a pharmacy benefit manager under this paragraph shall comply with National Council for Prescription Drug Programs (NCPDP) standards.

3. The department may stipulate how this data shall be prepared, forwarded, and provided by a pharmacy benefit manager to the department;

(j) 1. The amount of rebates received by a pharmacy benefit manager, or its contracted entity, from all pharmaceutical manufacturers, or contracted entities, for each Medicaid managed care organization client, for all Medicaid managed care organization clients contracted with the department to provide Medicaid benefits, and for the cabinet

or department. The rebate information provided by the pharmacy benefit manager shall include the amount of each rebate retained by the pharmacy benefit manager, or its contracted entity or controlling entity. Upon department request, any required rebate information shall include supplemental rebates.

2. The department may establish the format by which any data, including requested supplemental rebate information, is forwarded and provided under this paragraph, including on a per drug basis, per drug by client, per drug in aggregate, per claim, or in aggregate.

3. As used in this paragraph, "rebate":

a. Means all price concessions paid by a manufacturer, or its contracted entity, to a pharmacy benefit manager, including rebates, discounts, and other price concessions that are based on actual or estimated utilization of a prescription drug; and

b. Includes price concessions based on the effectiveness of a drug, as in a value-based or performance-based contract;

(k) 1. The amount of administrative fees that the pharmacy benefit manager, or its contracted entity, received from all pharmaceutical manufacturers, or contracted entities, for each Medicaid managed care organization client, for all Medicaid managed care organization clients contracted with the department to provide Medicaid benefits, and for the cabinet or department. Any information provide under this paragraph by the pharmacy benefit manager shall include the amount of each administrative fee retained by the pharmacy benefit manager, or its contracted entity or controlling entity.

2. The department may establish the format by which any data is forwarded and provided under this paragraph, including on a per

drug basis, per drug by client, per drug in aggregate, per claim, or in aggregate; and

(l) All common ownership, management, common members of a board of directors, shared managers, or control of a pharmacy benefit manager, or any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company with any managed care organization contracted to ***provide***~~[administer]~~ Kentucky Medicaid benefits, any entity which contracts on behalf of a pharmacy, or any pharmacy services administration organization; or any common ownership, management, common members of a board of directors, shared managers, or control of a pharmacy services administration organization that is contracted with a pharmacy benefit manager, with any drug wholesaler or distributor or any of the pharmacy services administration organization's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, common members of a board of directors, manager, or holding company.

(6)~~[(5)]~~ All information provided by a pharmacy benefit manager pursuant to subsection ***(5)***~~[(4)]~~ of this section shall reflect data for the most recent full calendar year and shall be divided by month. This information shall be managed by the department~~[for Medicaid Services]~~ in accordance with applicable law and shall be exempt from KRS 61.870 to 61.884 in accordance with KRS 61.878(1)(c).

(7)~~[(6)]~~ Any contract entered into or renewed for the delivery of Medicaid services by a managed care organization on or after July 1, 2018, shall comply with the following requirements:

(a) The department~~[for Medicaid Services]~~ shall set, create, or approve, and may change at any time for any reason, reimbursement rates between a pharmacy

benefit manager and a contracted pharmacy, or an entity which contracts on behalf of a pharmacy. Reimbursement rates shall include dispensing fees which take into account applicable guidance by the Center for Medicare and Medicaid Services. A pharmacy benefit manager shall notify the department~~[for Medicaid Services]~~ thirty (30) days in advance of any proposed change of over five percent (5%) in the product reimbursement rates for a pharmacy licensed in Kentucky. The department~~[for Medicaid Services]~~ may disallow the change within thirty (30) days of this notification;

(b) All laws and administrative regulations promulgated by the department~~[for Medicaid Services]~~, including but not limited to the regulation of maximum allowable costs;

(c) The department~~[for Medicaid Services]~~ shall approve any contract between the managed care organization and a pharmacy benefit manager;

(d) The department~~[for Medicaid Services]~~ shall approve any contract, any change in the terms of a contract, or suspension or termination of a contract between a pharmacy benefit manager contracted with a managed care organization to administer Medicaid benefits and an entity which contracts on behalf of a pharmacy, or any contract or any change in the terms of a contract, or any suspension or termination of a contract between a pharmacy benefit manager and a pharmacy or pharmacist; and

(e) Any fee established, modified, or implemented directly or indirectly by a managed care organization, pharmacy benefit manager, or entity which contracts on behalf of a pharmacy that is directly or indirectly charged to, passed onto, or required to be paid by a pharmacy services administration organization, pharmacy, or Medicaid recipient shall be submitted to the department~~[for Medicaid Services]~~ for approval. This paragraph shall not apply to any membership fee or service fee established, modified, or

implemented by a pharmacy services administration organization on a pharmacy licensed in Kentucky that is not directly or indirectly related to product reimbursement.

(8) ~~[(7)]~~ The department~~[for Medicaid Services]~~ may promulgate administrative regulations pursuant to KRS Chapter 13A as necessary to implement and administer its responsibilities under this section. These administrative regulations may include but are not limited to the assessment of fines, penalties, or sanctions for noncompliance.

(9) ~~[(8)]~~ The department~~[for Medicaid Services]~~ may consider any information ascertained pursuant to this section in the setting, creation, or approval of reimbursement rates used by a pharmacy benefit manager or an entity which contracts on behalf of a pharmacy.

(10) (a) A pharmacy benefit manager, or its contracted entity, shall comply with any reporting or other requirement of this section.

(b) Failure to comply in good faith with this section shall result in a civil penalty of twenty-five thousand dollars ($25,000) per day per violation.

(c) Submission of materially inaccurate or deliberately misleading information to the department under this section shall result in an additional civil penalty of twenty-five thousand dollars ($25,000) per day per inaccurate or misleading field of data submitted.

(11) Nothing in this section shall be construed to permit acts that are prohibited under Sections 2, 3, 4, or 5 of this Act.

➔Section 18. KRS 18A.2259 is amended to read as follows:

Any ***fully insured health benefit plan or*** self-insured plan ***issued or renewed on or after the effective date of this Act*** ~~[offered]~~ by the Personnel Cabinet shall***:***

(1) Include a mail-order drug option for maintenance drugs for public employees, and maintenance drugs may be dispensed by mail in accordance with Kentucky law. The

mail-order drug option shall not permit the dispensing of a controlled substance classified in Schedule II**;**~~[. The self-insured plan shall]~~

(2) Not discriminate***, which discrimination may include denying a pharmacy the opportunity to participate in a pharmacy network at preferred participation status,*** against any retail pharmacy located within the geographic coverage area of the plan that meets ***reasonable***~~[the]~~ terms and conditions for participation established by the plan, including price, dispensing fee,~~[and]~~ copay requirements of a mail-order drug option***, and obtaining preferred participation status***. The retail pharmacy shall not be required to dispense by mail. The net cost to the plan for a quantity of maintenance drugs dispensed by mail order shall not exceed the net cost to the plan for the same quantity of the same drug dispensed by a retail pharmacy under ***reasonable***~~[the]~~ terms and conditions established for dispensing and reimbursement at retail***; and***

(3) Comply with Sections 1, 2, 3, 4, and 5 of this Act.

➔Section 19. KRS 18A.225 is amended to read as follows:

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

1. Any person, including an elected public official, who is regularly employed by any department, office, board, agency, or branch of state government; or by a public postsecondary educational institution; or by any city, urban-county, charter county, county, or consolidated local government, whose legislative body has opted to participate in the state-sponsored health insurance program pursuant to KRS 79.080; and who is either a contributing member to any one (1) of the retirement systems administered by the state, including but not limited to the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, or the Judicial Retirement Plan; or is receiving a contractual contribution from the state toward a retirement

plan; or, in the case of a public postsecondary education institution, is an individual participating in an optional retirement plan authorized by KRS 161.567; or is eligible to participate in a retirement plan established by an employer who ceases participating in the Kentucky Employees Retirement System pursuant to KRS 61.522 whose employees participated in the health insurance plans administered by the Personnel Cabinet prior to the employer's effective cessation date in the Kentucky Employees Retirement System;

2. Any certified or classified employee of a local board of education;

3. Any elected member of a local board of education;

4. Any person who is a present or future recipient of a retirement allowance from the Kentucky Retirement Systems, Kentucky Teachers' Retirement System, the Legislators' Retirement Plan, the Judicial Retirement Plan, or the Kentucky Community and Technical College System's optional retirement plan authorized by KRS 161.567, except that a person who is receiving a retirement allowance and who is age sixty-five (65) or older shall not be included, with the exception of persons covered under KRS 61.702(4)(c), unless he or she is actively employed pursuant to subparagraph 1. of this paragraph; and

5. Any eligible dependents and beneficiaries of participating employees and retirees who are entitled to participate in the state-sponsored health insurance program;

(b) The term "health benefit plan" for the purposes of this section means a health benefit plan as defined in KRS 304.17A-005;

(c) The term "insurer" for the purposes of this section means an insurer as defined in KRS 304.17A-005; and

(d) The term "managed care plan" for the purposes of this section means a

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

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

during annual open enrollment.

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

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

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

(e) The Personnel Cabinet shall develop the necessary techniques and capabilities for timely analysis of data received from carriers and, to the extent possible, provide in the request-for-proposal specifics relating to data requirements, electronic reporting, and penalties for noncompliance. The Commonwealth shall own the enrollment, claims, and utilization data provided by each carrier

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

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

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

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

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

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

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

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

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

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

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

(7) Group rates under this section shall be made available to the disabled child of an

employee regardless of the child's age if the entire premium for the disabled child's coverage is paid by the state employee. A child shall be considered disabled if he has been determined to be eligible for federal Social Security disability benefits.

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

(9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of State Health Insurance Subscribers to advise the secretary or his designee regarding the state-sponsored health insurance program for employees. The secretary shall appoint, from a list of names submitted by appointing authorities, members representing school districts from each of the seven (7) Supreme Court districts, members representing state government from each of the seven (7) Supreme Court districts, two (2) members representing retirees under age sixty-five (65), one (1) member representing local health departments, two (2) members representing the Kentucky Teachers' Retirement System, and three (3) members at large. The secretary shall also appoint two (2) members from a list of five (5) names submitted by the Kentucky Education Association, two (2) members from a list of five (5) names submitted by the largest state employee organization of nonschool state employees, two (2) members from a list of five (5) names submitted by the Kentucky Association of Counties, two (2) members from a list of five (5) names submitted by the Kentucky League of Cities, and two (2) members from a list of names consisting of five (5) names submitted by each state employee organization that has two thousand (2,000) or more members on state payroll deduction. The advisory committee shall be appointed in January of each year and shall meet quarterly.

(10) Notwithstanding any other provision of law to the contrary, the policy or policies provided to employees pursuant to this section shall not provide coverage for obtaining or performing an abortion, nor shall any state funds be used for the

purpose of obtaining or performing an abortion on behalf of employees or their dependents.

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

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

(13) ~~[(a)]~~The ***policy or*** policies of health insurance coverage procured under subsection (2) of this section shall ***comply with Section 18 of this Act***~~[include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.~~

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

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

(14) The policy or policies provided to state employees or their dependents pursuant to this section shall provide coverage for obtaining a hearing aid and acquiring hearing

aid-related services for insured individuals under eighteen (18) years of age, subject to a cap of one thousand four hundred dollars ($1,400) every thirty-six (36) months pursuant to KRS 304.17A-132.

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

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

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

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

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

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

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

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

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

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

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

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

osteopaths.

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

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

(24) Any fully insured health benefit plan or self-insured plan issued or renewed on or after July 1, 2019, to public employees pursuant to this section shall comply with KRS 304.17A-138.

➔Section 20. If any provision of this Act, or this Act's application to any person or circumstance, is held invalid, the invalidity shall not affect other provisions or applications of the Act, which shall be given effect without the invalid provision or application, and to this end the provisions and applications of this Act are severable.

➔Section 21. This Act takes effect on January 1, 2021.