AN ACT relating to consumer protections in health insurance.

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

➔Section 1. KRS 304.17A-0952 is amended to read as follows:

***(1) Except as provided in subsection (2) of this section,*** premium rates for a health benefit plan issued or renewed to an individual, a small group, or an association on or after April 10, 1998, shall be subject to the following provisions:

***(a)*** ~~[(1)]~~ The premium rates charged during a rating period to an individual with similar case characteristics for the same coverage, or the rates that could be charged to that individual under the rating system for that class of business, shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal, on or after January 1, 2003**.** ~~[.]~~

***(b)*** ~~[(2)]~~ Notwithstanding the thirty-five percent (35%) variance limitation in ***paragraph (a) of this subsection*** ~~[subsection (1) of this section]~~, insurers offering an individual health benefit plan that is state-elected under sec. 35(e)(1)F of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201, may vary from the index rate by more than thirty-five percent (35%) for individuals who are eligible for the health coverage tax credit under the following conditions:

***1.*** ~~[(a)]~~ The insurer certifies that the individual does not meet the insurer's underwriting guidelines for issuance of an individual policy;

***2.*** ~~[(b)]~~ The policy meets the requirements for state-elected coverage under the Trade Act of 2002; and

***3.*** ~~[(c)]~~ The premium rate is actuarially justified and has been approved by the Department of Insurance pursuant to KRS 304.17A-095**;** ~~[.]~~

***(c)*** ~~[(3)]~~ The percentage increase in the premium rate charged to an individual for a new rating period shall not exceed the sum of the following:

***1.*** ~~[(a)]~~ The percentage change in the new business premium rate measured

from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

***2.***~~[(b)]~~ Any adjustment, not to exceed twenty percent (20%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the individual and dependents as determined from the insurer's rate manual for the class of business; and

***3.***~~[(c)]~~ Any adjustment due to change in coverage or change in the case characteristics of the individual as determined from the insurer's rate manual for the class of business**;**~~[.]~~

***(d)***~~[(4)]~~ The premium rates charged during a rating period to a small group or to an association member with similar case characteristics for the same coverage, or the rates that could be charged to that small group or that association member under the rating system for that class of business, shall not vary from the index rate by more than fifty percent (50%) of the index rate**;**~~[.]~~

***(e)***~~[(5)]~~ The percentage increase in the premium rate charged to a small group or to an association member for a new rating period shall not exceed the sum of the following:

***1.***~~[(a)]~~ The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the insurer is not issuing new policies, the insurer shall use the percentage change in the base premium rate;

***2.***~~[(b)]~~ Any adjustment, not to exceed twenty percent (20%) annually and

adjusted pro rata for rating periods of less than one (1) year, due to the claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, or duration of coverage of the employee, association member, or dependents as determined from the insurer's rate manual for the class of business; and

***3.***~~[(c)]~~ Any adjustment due to change in coverage or change in the case characteristics of the small group or association member as determined from the insurer's rate manual for the class of business***;***~~[.]~~

***(f)***~~[(6)]~~ In utilizing case characteristics, the ratio of the highest rate factor to the lowest rate factor within a class of business shall not exceed five to one (5:1). For purpose of this limitation, case characteristics include age, gender, occupation or industry, and geographic area***;***~~[.]~~

***(g)***~~[(7)]~~ Adjustments in rates for claims experience, mental and physical condition, including medical condition, medical history, and health service utilization, health status, and duration of coverage shall not be charged to an individual group member or the member's dependents. Any adjustment shall be applied uniformly to the rates charged for all individuals and dependents of the small group***;***~~[.]~~

***(h)***~~[(8)]~~ ***1.*** The commissioner may approve establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the additional class would enhance the efficiency and fairness for the applicable market segment.

***2.***~~[(a)]~~ The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business in that market segment by more than ten percent (10%).

***3.***~~[(b)]~~ An insurer may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative

cost related to the following reasons:

***a.***~~[1.]~~ The insurer uses more than one (1) type of system for the marketing and sale of the health benefit plans;

***b.***~~[2.]~~ The insurer has acquired a class of business from another insurer; or

***c.***~~[3.]~~ The insurer is offering a state-elected plan under the provisions of the Trade Act of 2002, Pub. L. No. 107-210 sec. 201.

***4.***~~[(c)]~~ Notwithstanding any other provision of this ***paragraph***~~[subsection]~~, beginning January 1, 2001, a GAP participating insurer may establish a separate class of business for the purpose of separating guaranteed acceptance program qualified individuals from other individuals enrolled in their plan prior to January 1, 2001. The index rate for the separate class created under this paragraph shall be established taking into consideration expected claims experience and administrative costs of the new class of business and the previous class of business***;***~~[.]~~

***(i)***~~[(9)]~~ For the purpose of this ***subsection***~~[section]~~, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize a restricted provider network if utilization of the restricted provider network results in substantial differences in claims costs***;***~~[.]~~

***(j)***~~[(10)]~~ Notwithstanding any other provision of this ***subsection***~~[section]~~, an insurer shall not be required to utilize the experience of those individuals with high-cost conditions who enrolled in its plans between July 15, 1995, and April 10, 1998, to develop the insurer's index rate for its individual policies***; and***~~[.]~~

***(k)***~~[(11)]~~ Nothing in this ***subsection***~~[section]~~ shall be construed to prevent an

insurer from offering incentives to participate in a program of disease prevention or health improvement.

***(2) (a) Notwithstanding any other provision of this chapter, a premium rate for a health benefit plan originally issued on or after January 1, 2014, in the individual or small group market shall vary with respect to the particular plan only by the following case characteristics:***

***1. Family composition;***

***2. Geographic region;***

***3. Age, except the ratio of the highest rate factor to the lowest rate factor shall not exceed three to one (3:1); and***

***4. Tobacco use, except that the ratio of the highest rate factor to the lowest rate factor shall not exceed one and five tenths to one (1.5:1).***

***(b) The commissioner may promulgate an administrative regulation to establish the following:***

***1. The family composition tiers for purposes of paragraph (a)1. of this subsection;***

***2. The geographic region for purposes of paragraph (a)2. of this subsection; and***

***3. The age bands for purposes of paragraph (a)3. of this subsection.***

➔SECTION 2. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) All health benefit plans shall continue to make coverage available for an adult child until the attainment of age twenty-six (26).***

***(2) Nothing in this section shall require a health benefit plan to cover the child of a child receiving dependent coverage under a health benefit plan.***

➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

***(1) Except as provided in subsection (3) of this section, all health benefit plans shall cover preventive services, including:***

***(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved, except as provided in 45 C.F.R. sec. 147.130;***

***(b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC;***

***(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and***

***(d) With respect to women, to the extent not described in paragraph (a) of this subsection, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.***

***(2) The coverage required by this section shall not be subject to a deductible, coinsurance, copayments, or any other cost-sharing requirements.***

***(3) This section shall not apply to:***

***(a) Health benefit plans originally issued prior to March 23, 2010; or***

***(b) Services delivered by a nonparticipating provider if the health benefit plan utilizes a network of providers.***

➔Section 4. KRS 304.17-310 is amended to read as follows:

(1) Family expense health insurance is that provided under a policy issued to one (1) of

the family members insured, who shall be deemed the policyholder, covering any two (2) or more eligible members of a family, including husband, wife, unmarried dependent children, to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support,~~[ and]~~ any other person dependent upon the policyholder***, and persons otherwise required to be covered under Section 2 of this Act***. Any authorized health insurer may issue the insurance.

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

(3) ***Except as provided in Section 2 of this Act,*** insurers offering family expense health insurance shall offer the applicant the option to purchase coverage for unmarried dependent children until age twenty-five (25).

➔Section 5. KRS 304.17-030 is amended to read as follows:

No policy of health insurance shall be delivered or issued for delivery to any person in

this state unless it otherwise complies with this title, and complies with the following:

(1) The entire money and other considerations therefor shall be expressed therein;

(2) The time when the insurance takes effect and terminates shall be expressed therein;

(3) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife,~~[ unmarried dependent children to age nineteen (19), unmarried children from nineteen (19) to twenty-five (25) years of age who are full-time students enrolled in and attending an accredited educational institution and who are primarily dependent on the policyholder for maintenance and support,]~~ and ***persons*** ~~[any other person dependent upon the policyholder]~~ as provided pursuant to KRS 304.17-310;

(4) The style, arrangement, and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred and twenty (120) point (the "text" shall include all printed matter except the name and address of the insurer, name on title of the policy, the brief description, if any, and captions and subcaptions);

(5) The exceptions and reductions of indemnity shall be set forth in the policy and other than those contained in KRS 304.17-050 to 304.17-290, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and indorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) The policy shall contain no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

➔Section 6. KRS 304.17-190 is amended to read as follows:

***Except as provided in Section 1 of this Act,*** there may be a provision as follows:

"Change of Occupation: If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rate and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state

prior to the occurrence of the loss or prior to the date of proof of change in occupation."

➔Section 7. KRS 304.17-390 is amended to read as follows:

(1) Health insurance on a franchise plan is that issued to:

(a) Five (5) or more employees of a common employer; or

(b) Ten (10) or more members of any bona fide association or labor union, which association or union was formed and exists for purposes other than that of obtaining insurance, and under which such employees or members, with or without their dependents, are issued individual policies which may vary as to amounts and kinds of coverage as applied for, under an arrangement whereby the premiums on the policies are to be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association, or by some designated employee or officer of the association acting on behalf of the employer or association members.

(2) Disability insurance on a franchise plan is that issued for:

(a) Three (3) or more employees of a common employer; or

(b) Ten (10) or more members of any bona fide association or labor union, which association or union was formed and exists for purposes other than that of obtaining insurance, and under which the employees or members, with or without their dependents, are issued individual policies which may vary as to amounts and kinds of coverage as applied for, under an arrangement whereby the premiums on the policies are to be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association, or by some designated employee or officer of the association acting on behalf of the employer or association members.

(3) The term "employees" includes also the employer's officers, and the employer or partners if the employer is an individual or a partnership.

(4) ***Except as provided in Section 1 of this Act,*** an insurer may charge different rates, provide different benefits, or employ different underwriting procedure for individuals insured under a franchise plan, if such rates, benefits, or procedures as used do not unfairly discriminate as between individuals insured under franchise plans and individuals otherwise insured under similar policies, taking into consideration the insuring, risk and exposure factors, and expense elements.

➔Section 8. 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 policies of health insurance coverage procured under subsection (2) of this section shall include a mail-order drug option for maintenance drugs for state employees. Maintenance drugs may be dispensed by mail order in accordance with Kentucky law.

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

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

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

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

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

to KRS 304.17A-258.

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

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

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

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

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

(b) The Personnel Cabinet shall divide the state into geographical regions which

shall be the same as the partnership regions designated by the Department for Medicaid Services for purposes of the Kentucky Health Care Partnership Program established pursuant to 907 KAR 1:705;

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

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

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

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

(22) Any fully insured health benefit plan or self-insured plan issued or renewed on or after ***the effective date of this Act***~~[July 12, 2006]~~, to public employees pursuant to this section shall comply with***:***

***(a) Sections 2 and 3 of this Act;***

***(b)*** ~~[the provisions of ]~~KRS 304.17A-270 and 304.17A-525***;***

***(c) KRS 304.17A-600 to 304.17A-633;***

***(d) KRS 205.593;***

***(e) KRS 304.17A-700 to 304.17A-730;***

***(f) KRS 304.14-135;***

***(g) KRS 304.17A-580 and 304.17A-641;***

***(h) KRS 304.99-123;***

***(i) KRS 304.17A-138; and***

***(j) Administrative regulations promulgated pursuant to statutes listed in this subsection***.

~~[(23) Any fully insured health benefit plan or self-insured plan issued or renewed on or after 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 9. The following KRS section is repealed:

304.17A-256 Options for dependent coverage under group health benefit plans -- Disclaimer.