1 AN ACT relating to coverage for pharmacy and pharmacist services.
2 ***Be it enacted by the General Assembly of the Commonwealth of Kentucky:***
3 ➔SECTION 1. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304
4 IS CREATED TO READ AS FOLLOWS:
5 ***(1) (a) A pharmacy benefit manager that utilizes a network of contracted***
6 ***pharmacies shall:***
7 ***1. Not discriminate against any pharmacist or pharmacy that is:***
8 ***a. Located within the geographic coverage area of the pharmacy***
9 ***benefit manager's network; and***
10 ***b. Willing to meet the terms and conditions for participation in the***
11 ***pharmacy benefit manager's network that are related to***
12 ***reimbursement for services; and***
13 ***2. Ensure that its network is reasonably adequate and accessible for the***
14 ***provision of prescription drug benefits.***
15 ***(b) In order to meet the requirements of this subsection, the pharmacy benefit***
16 ***manager's network shall:***
17 ***1. Provide convenient patient access to pharmacies within a reasonable***
18 ***distance from a patient's residence, no greater than the distance***
19 ***established for Medicare Part D Plans; and***
20 ***2. Exclude a mail-order pharmacy in the determination of reasonably***
21 ***adequate and accessible.***
22 ***(c) The termination of a pharmacy from a pharmacy benefit manager's***
23 ***network shall not release the pharmacy benefit manager from the***
24 ***obligation to make any payments owed to the pharmacy for services***
25 ***rendered prior to the termination.***
26 ***(2) (a) The commissioner may review and approve a pharmacy benefit manager's***
27 ***compensation program to ensure that:***

1 ***1. Reimbursement for pharmacy or pharmacist services to a pharmacy or***
2 ***pharmacist is fair and reasonable; and***
3 ***2. It does not impede the maintenance of a reasonably adequate and***
4 ***accessible network.***
5 ***(b) All information and data acquired by the department during a review under***
6 ***this subsection shall be considered proprietary and confidential and shall***
7 ***not be subject to disclosure under the Kentucky Open Records Act, KRS***
8 ***61.870 to KRS 61.884.***
9 ***(3) A pharmacy benefit manager shall not:***
10 ***(a) Cause, or knowingly permit, the use of any advertisement, promotion,***
11 ***solicitation, representation, proposal, or offer that is untrue, deceptive, or***
12 ***misleading;***
13 ***(b) Require pharmacy accreditation standards or certification requirements***
14 ***inconsistent with, more stringent than, or in addition to requirements of the***
15 ***Board of Pharmacy;***
16 ***(c) Share an insured's information received from an independent pharmacy***
17 ***with an affiliated pharmacy;***
18 ***(d) Directly or indirectly charge a pharmacy a fee:***
19 ***1. Related to a claim:***
20 ***a. If the fee is not apparent at the time of claim processing; or***
21 ***b. After the initial claim is adjudicated at the point of sale;***
22 ***2. Related to the adjudication of a claim, unless it has been reviewed and***
23 ***approved by the commissioner, including but not limited to a fee for:***
24 ***a. The receipt and processing of a pharmacy claim;***
25 ***b. The development or management of claims processing services***
26 ***in a pharmacy benefit manager network; or***
27 ***3. Related to:***

1 ***a. Participation in a pharmacy benefit manager network; or***
2 ***b. Performance metrics on the cost of goods sold by a pharmacy;***
3 ***(e) Reimburse, or provide incentives to, an independent pharmacy in an***
4 ***amount or at a value that is less than the amount or value that it reimburses***
5 ***or incentivizes an affiliated pharmacy for providing the same pharmacy or***
6 ***pharmacist services; or***
7 ***(f) Own or have an ownership interest in a patient assistance program and a***
8 ***mail order specialty pharmacy, unless the pharmacy benefit manager agrees***
9 ***to not participate in a transaction that benefits it instead of another person***
10 ***owed a fiduciary duty.***
11 ***For purposes of this paragraph a pharmacy benefit manager includes any***
12 ***affiliates or subsidiaries of the pharmacy benefit manager.***
13 ***(4) In order to effectuate, or as an aid to the effectuation of, any provision of this***
14 ***section, the commissioner may promulgate administrative regulations that***
15 ***prohibit practices by pharmacy benefit managers providing claims processing***
16 ***services or other prescription drug or device services.***
17 ➔Section 2. KRS 304.17A-161 is amended to read as follows:
18 As used in this section and KRS 304.17A-162, 304.17A-163, ***Section 4 of this Act,***[and]
19 304.17A-165***, and Section 1 of this Act,*** unless the context requires otherwise:
20 (1) "Contracted pharmacy" or "pharmacy" means a pharmacy located in Kentucky
21 participating in the network of a pharmacy benefit manager through a direct contract
22 or through a contract with a pharmacy services administration organization or group
23 purchasing organization;
24 (2) "Drug product reimbursement" means the amount paid by a pharmacy benefit
25 manager to a contracted pharmacy for the cost of the drug dispensed to a patient and
26 does not include a dispensing or professional fee;
27 (3) ***"Independent pharmacy" means a pharmacy:***

1 ***(a) In which a pharmacy benefit manager does not have an ownership interest,***
2 ***either directly or through an affiliate or subsidiary; and***
3 ***(b) That does not have an ownership interest, either directly or through an***
4 ***affiliate or subsidiary, in a pharmacy benefit manager;***
5 ***(4)*** "Maximum allowable cost" means the maximum amount that a pharmacy benefit
6 manager will reimburse a pharmacy for the cost of a generic drug and does not
7 include a dispensing or professional fee;~~[and]~~
8 ***(5)***~~[(4)]~~ "Pharmacy benefit manager" means an entity that, on behalf of a health benefit
9 plan, state agency, insurer, managed care organization providing services under
10 KRS Chapter 205, or other third-party payor:
11 (a) Contracts directly or indirectly with pharmacies to provide prescription drugs
12 to individuals;
13 (b) Administers a prescription drug benefit;
14 (c) Processes or pays pharmacy claims;
15 (d) Creates or updates prescription drug formularies;
16 (e) Makes or assists in making prior authorization determinations on prescription
17 drugs;
18 (f) Administers rebates on prescription drugs; or
19 (g) Establishes a pharmacy network***; and***
20 ***(6) "Specialty drug" means a prescription drug that:***
21 ***(a) Is not available for order or purchase by a retail community pharmacy or***
22 ***long-term care pharmacy, regardless of whether the drug is meant to be***
23 ***self-administered; and***
24 ***(b) Requires special storage and has distribution or inventory limitations not***
25 ***available at a retail community pharmacy or long-term care pharmacy***.
26 ➔Section 3. KRS 304.17A-162 is amended to read as follows:
27 (1) A pharmacy benefit manager shall:

1 (a) Identify to contracted pharmacies the sources used by the pharmacy benefit
2 manager to calculate the drug product reimbursement paid for covered drugs
3 available under the pharmacy health benefit plan administered by the
4 pharmacy benefit manager; and
5 (b) Establish a process for contracted pharmacies, pharmacy services
6 administration organizations, or group purchasing organizations to appeal and
7 resolve disputes regarding the maximum allowable cost pricing. The process
8 shall include the following provisions:
9 1. The right to appeal shall be limited to sixty (60) days following the
10 initial claim;
11 2. The appeal shall be investigated and resolved by the pharmacy benefit
12 manager within ten (10) calendar days;
13 3. The pharmacy benefit manager shall respond to all appeals in a manner
14 approved by the department;
15 4. If the appeal is denied, the pharmacy benefit manager shall provide the
16 reason for the denial and identify the national drug code of ***the***~~[a]~~ drug
17 product and source where it may be purchased from a licensed
18 wholesaler by contracted pharmacies at a price at or below the maximum
19 allowable cost; and
20 5. If an appeal is granted, the provisions of subsection (2) of this section
21 shall apply.
22 (2) If a price update is warranted as a result of an appeal granted under subsection (1) of
23 this section, the pharmacy benefit manager shall:
24 (a) Make the change in the maximum allowable cost to the initial date of service
25 the appealed drug was dispensed;
26 (b) Adjust the maximum allowable cost of the drug for the appealing pharmacy
27 and for all other contracted pharmacies in the network of that pharmacy

benefit manager that filled a prescription for patients covered under the same health benefit plan to the initial date of service the appealed drug was dispensed;

(c) ***Automatically reverse and resubmit the claim for all contracted pharmacies impacted by the granted appeal to the date of service the drug was dispensed***[~~Individually notify all other contracted pharmacies in the network of that pharmacy benefit manager that a retroactive maximum allowable cost adjustment has been made as a result of a granted appeal effective to the initial date of service the appealed drug was dispensed~~];

(d) Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted maximum allowable cost if applicable to their contract; ***and***

(e) [~~Allow the appealing pharmacy and all other contracted pharmacies in the network that filled prescriptions for patients covered under the same health benefit plan to reverse and resubmit claims and receive payment based on the adjusted maximum allowable cost from the initial date of service the appealed drug was dispensed; and~~

~~(f)~~]Make retroactive price adjustments in the next payment cycle.

(3) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to all contracted pharmacies information identifying the national drug pricing compendia or sources used to obtain the drug price data in a manner established by administrative regulations promulgated by the department.

(4) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall make available to all contracted pharmacies in a manner established by administrative regulations promulgated by the department the comprehensive list

1 of drugs subject to maximum allowable cost and the actual maximum allowable
2 cost for each drug.
3 (5) For every drug for which the pharmacy benefit manager establishes a maximum
4 allowable cost to determine the drug product reimbursement, the pharmacy benefit
5 manager shall make available to the department, upon request, information that is
6 needed to resolve an appeal. If the department is unable to obtain information from
7 the pharmacy benefit manager that is necessary to resolve the appeal, the appeal
8 shall be granted to the appealing pharmacy.
9 (6) For every drug for which the pharmacy benefit manager establishes a maximum
10 allowable cost to determine the drug product reimbursement, the pharmacy benefit
11 manager shall review and make necessary adjustments to the maximum allowable
12 cost for every drug at least every seven (7) calendar days and shall immediately
13 utilize the updated maximum allowable cost in calculating the payments made to all
14 contracted pharmacies.
15 (7) For every drug for which the pharmacy benefit manager establishes a maximum
16 allowable cost to determine the drug product reimbursement, the pharmacy benefit
17 manager shall make available to all contracted pharmacies in a manner established
18 by administrative regulations promulgated by the department weekly updates to the
19 list of drugs subject to maximum allowable cost and the actual maximum allowable
20 cost for each drug.
21 (8) For every drug for which the pharmacy benefit manager establishes a maximum
22 allowable cost to determine the drug product reimbursement, the pharmacy benefit
23 manager shall ensure that drugs subject to maximum allowable costs are:
24 (a) Generally available for purchase by pharmacists and pharmacies in Kentucky
25 from a national or regional wholesaler licensed in Kentucky by the Kentucky
26 Board of Pharmacy;
27 (b) Not obsolete, temporarily unavailable, or listed on a drug shortage list; and

1 (c) 1. Drugs that have an "A" or "B" rating in the most recent version of the
2 United States Food and Drug Administration's Approved Drug Products
3 with Therapeutic Equivalence Evaluations, also known as the Orange
4 Book; or
5 2. Drugs rated "NR" or "NA" or have a similar rating by a nationally
6 recognized reference.
7 (9) For every drug for which the pharmacy benefit manager establishes a maximum
8 allowable cost to determine the drug product reimbursement, the pharmacy benefit
9 manager shall ensure that reimbursement for a drug subject to maximum allowable
10 cost is based solely on that drug and drugs that are therapeutically equivalent if the
11 therapeutically equivalent drugs are listed in the most recent version of the United
12 States Food and Drug Administration Approved Drug Products with Therapeutic
13 Equivalence Evaluations, also known as the Orange Book.
14 (10) For every drug for which the pharmacy benefit manager establishes a maximum
15 allowable cost to determine the drug product reimbursement, the pharmacy benefit
16 manager shall ensure that reimbursement for a "B" rated drug subject to maximum
17 allowable cost is based solely on that drug and drugs that are not therapeutically
18 equivalent to a "B" rating in the most recent version of the United States Food and
19 Drug Administration Approved Drug Products with Therapeutic Equivalence
20 Evaluations, also known as the Orange Book.
21 (11) For every drug for which the pharmacy benefit manager establishes a maximum
22 allowable cost to determine the drug product reimbursement, the pharmacy benefit
23 manager shall ensure that reimbursement for a "NR" or "NA" drug with a similar
24 rating by a nationally recognized reference subject to maximum allowable cost is
25 based solely on that drug and other drugs with a "NR" or "NA" rating or similar
26 rating by a nationally recognized reference that meets criteria for therapeutic
27 equivalence used in the United States Food and Drug Administration Approved

Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book.

(12) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a drug subject to maximum allowable cost is based solely on that drug if there is no other therapeutically equivalent drug.

(13) For every drug for which the pharmacy benefit manager establishes a maximum allowable cost to determine the drug product reimbursement, the pharmacy benefit manager shall ensure that reimbursement for a drug subject to maximum allowable cost is not based on a drug that is obsolete, temporarily unavailable, listed on a drug shortage list, or that cannot be lawfully substituted.

➔Section 4. KRS 304.17A-164 is amended to read as follows:

(1) As used in this section:

(a) "Cost sharing" means the cost to 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; ***and***

(c) "Pharmacy" includes:

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

2. A pharmacist, as defined in KRS Chapter 315; or

3. Any employee of a pharmacy or pharmacist[~~; and~~

~~(d) "Pharmacy benefit manager" has the same meaning as in KRS 304.17A-161~~].

(2) An insurer issuing or renewing a health benefit plan on or after ***the effective date of***

1 ***this Act***~~[January 1, 2019]~~, or pharmacy benefit manager***:***

2 ***(a)*** Shall not:

3 ***1.***~~[(a)]~~ Require an insured purchasing a prescription drug to pay a cost-

4 sharing amount greater than the amount the insured would pay for the

5 drug if he or she were to purchase the drug without coverage under a

6 health benefit plan;

7 ***2.***~~[(b)]~~ Prohibit a pharmacy from discussing any information under

8 subsection (3) of this section;~~[and]~~

9 ***3.***~~[(c)]~~ Impose a penalty on a pharmacy for complying with this section~~[.~~

10 ~~]~~***;***

11 ***4. Prohibit a pharmacy from providing an insured a prescription by mail***

12 ***or other delivery method;***

13 ***5. Require insureds to receive pharmacy or pharmacist services from a***

14 ***mail-order pharmacy or an affiliated pharmacy, or select the insured's***

15 ***use of pharmacy or pharmacist services by mail or from an affiliated***

16 ***pharmacy;***

17 ***6 Use a different cost-sharing amount for prescriptions filled from an***

18 ***affiliated mail-order or retail pharmacy;***

19 ***7. Designate a drug as a specialty drug, if the drug does not meet the***

20 ***definition under Section 2 of this Act; or***

21 ***8. Retroactively deny or reduce a claim for pharmacy or pharmacist***

22 ***services after adjudication of the claim unless:***

23 ***a. The original claim was submitted fraudulently;***

24 ***b. The original claim payment was incorrect because the pharmacy***

25 ***or pharmacist had previously been paid for those services; or***

26 ***c. The services were not properly provided by the pharmacy or***

27 ***pharmacist; and***

1 ***(b) Shall reimburse a contracted pharmacy after the pharmacy has***
2 ***properly dispensed a specialty drug.***
3 (3) A pharmacist shall have the right to provide an insured information regarding the
4 applicable limitations on his or her cost-sharing pursuant to this section for a
5 prescription drug.
6 (4) Any amount paid by an insured under subsection (2)(a)***1.*** of this section shall be
7 attributable toward any annual out-of-pocket maximums under the insured's health
8 benefit plan.
9 ➔Section 5. KRS 304.17A-005 (Effective July 1, 2019) is amended to read as
10 follows:
11 As used in this subtitle, unless the context requires otherwise:
12 (1) "Association" means an entity, other than an employer-organized association, that
13 has been organized and is maintained in good faith for purposes other than that of
14 obtaining insurance for its members and that has a constitution and bylaws;
15 (2) "At the time of enrollment" means:
16 (a) At the time of application for an individual, an association that actively
17 markets to individual members, and an employer-organized association that
18 actively markets to individual members; and
19 (b) During the time of open enrollment or during an insured's initial or special
20 enrollment periods for group health insurance;
21 (3) "Base premium rate" means, for each class of business as to a rating period, the
22 lowest premium rate charged or that could have been charged under the rating
23 system for that class of business by the insurer to the individual or small group, or
24 employer as defined in KRS 304.17A-0954, with similar case characteristics for
25 health benefit plans with the same or similar coverage;
26 (4) "Basic health benefit plan" means any plan offered to an individual, a small group,
27 or employer-organized association that limits coverage to physician, pharmacy,

1 home health, preventive, emergency, and inpatient and outpatient hospital services
2 in accordance with the requirements of this subtitle. If vision or eye services are
3 offered, these services may be provided by an ophthalmologist or optometrist.
4 Chiropractic benefits may be offered by providers licensed pursuant to KRS
5 Chapter 312;
6 (5) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-
7 91(d)(3);
8 (6) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);
9 (7) "COBRA" means any of the following:
10 (a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric
11 vaccines;
12 (b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161
13 et seq. other than sec. 1169); or
14 (c) 42 U.S.C. sec. 300bb;
15 (8) [(a)]"Creditable coverage"***:***
16 ***(a)*** Means, with respect to an individual, coverage of the individual under any of
17 the following:
18 1. A group health plan;
19 2. Health insurance coverage;
20 3. Part A or Part B of Title XVIII of the Social Security Act;
21 4. Title XIX of the Social Security Act, other than coverage consisting
22 solely of benefits under section 1928;
23 5. Chapter 55 of Title 10, United States Code, including medical and dental
24 care for members and certain former members of the uniformed services,
25 and for their dependents; for purposes of Chapter 55 of Title 10, United
26 States Code, "uniformed services" means the Armed Forces and the
27 Commissioned Corps of the National Oceanic and Atmospheric

1 Administration and of the Public Health Service;
2 6. A medical care program of the Indian Health Service or of a tribal
3 organization;
4 7. A state health benefits risk pool;
5 8. A health plan offered under Chapter 89 of Title 5, United States Code,
6 such as the Federal Employees Health Benefit Program;
7 9. A public health plan as established or maintained by a state, the United
8 States government, a foreign country, or any political subdivision of a
9 state, the United States government, or a foreign country that provides
10 health coverage to individuals who are enrolled in the plan;
11 10. A health benefit plan under section 5(e) of the Peace Corps Act (22
12 U.S.C. sec. 2504(e)); or
13 11. Title XXI of the Social Security Act, such as the State Children's Health
14 Insurance Program***; and***[~~.~~]
15 (b) [~~This term~~]Does not include coverage consisting solely of coverage of
16 excepted benefits as defined in[~~ subsection (14) of~~] this section;
17 (9) "Dependent" means any individual who is or may become eligible for coverage
18 under the terms of an individual or group health benefit plan because of a
19 relationship to a participant;
20 (10) ***"Eligible individual" means an individual:***
21 ***(a) For whom, as of the date on which the individual seeks coverage, the***
22 ***aggregate of the periods of creditable coverage is eighteen (18) or more***
23 ***months and whose most recent prior creditable coverage was under a group***
24 ***health plan, governmental plan, or church plan. A period of creditable***
25 ***coverage under this paragraph shall not be counted if, after that period,***
26 ***there was a sixty-three (63) day period of time, excluding any waiting or***
27 ***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;

(11) "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; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, 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.

Except as provided in KRS 304.17A-200[~~, 304.17A.210,~~] and 304.17A-220, and except as otherwise provided by the definition of "large group" contained in[~~ subsection (30) of~~] this section, an employer-organized association shall not be

treated as an association, small group, or large group under this subtitle, provided that an employer-organized association that is a bona fide association as defined in[~~subsection (5) of~~] this section 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 thereof, 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

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

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

1 insurer or is a stop loss carrier, on or before December 31, 2000, provided that a
2 guaranteed acceptance plan supporting insurer shall not include an employer-
3 sponsored self-insured health benefit plan exempted by ERISA;
4 (22) "Health benefit plan"***:***
5 ***(a)*** Means any***:***
6 ***1.*** Hospital or medical expense policy or certificate;
7 ***2.*** Nonprofit hospital, medical-surgical, and health service corporation
8 contract or certificate;
9 ***3.*** Provider sponsored integrated health delivery network;
10 ***4.*** ~~[a]~~Self-insured plan or a plan provided by a multiple employer welfare
11 arrangement, to the extent permitted by ERISA;
12 ***5.*** Health maintenance organization contract; or
13 ***6.*** ~~[any]~~Health benefit plan that affects the rights of a Kentucky insured
14 and bears a reasonable relation to Kentucky, whether delivered or issued
15 for delivery in Kentucky***;***~~[,]~~ and
16 ***(b)*** Does not include***:***
17 ***1.*** Policies covering only accident, credit, dental, disability income, fixed
18 indemnity medical expense reimbursement~~[policy]~~, long-term care,
19 Medicare supplement, specified disease, ***or*** vision care***;***~~[,]~~
20 ***2.*** Coverage issued as a supplement to liability insurance***;***~~[,]~~
21 ***3.*** Insurance arising out of a workers' compensation or similar law***;***~~[,]~~
22 ***4.*** Automobile medical-payment insurance***;***~~[,]~~
23 ***5.*** Insurance under which benefits are payable with or without regard to
24 fault and that is statutorily required to be contained in any liability
25 insurance policy or equivalent self-insurance***;***~~[,]~~
26 ***6.*** Short-term coverage***;***~~[,]~~
27 ***7.*** Student health insurance offered by a Kentucky-licensed insurer under

1 written contract with a university or college whose students it proposes
2 to insure***;***~~[,]~~
3 ***8.*** Medical expense reimbursement policies specifically designed to fill
4 gaps in primary coverage, coinsurance, or deductibles and provided
5 under a separate policy, certificate, or contract***;***~~[, or]~~
6 ***9.*** Coverage supplemental to the coverage provided under Chapter 55 of
7 Title 10, United States Code~~[, or]~~
8 ***10.*** Limited health service benefit plans***;***~~[,]~~ or
9 ***11.*** Direct primary care agreements established under KRS 311.6201,
10 311.6202, 314.198, and 314.199;
11 (23) "Health care provider" or "provider" means any facility or service required to be
12 licensed pursuant to KRS Chapter 216B, a pharmacist ***or pharmacy*** as defined
13 pursuant to KRS Chapter 315, or home medical equipment and services provider as
14 defined pursuant to KRS 309.402, and any of the following independent practicing
15 practitioners:
16 (a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;
17 (b) Chiropractors licensed under KRS Chapter 312;
18 (c) Dentists licensed under KRS Chapter 313;
19 (d) Optometrists licensed under KRS Chapter 320;
20 (e) Physician assistants regulated under KRS Chapter 311;
21 (f) Advanced practice registered nurses licensed under KRS Chapter 314; and
22 (g) Other health care practitioners as determined by the department by
23 administrative regulations promulgated under KRS Chapter 13A;
24 (24) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance
25 Program, means a covered condition in an individual policy as listed in
26 paragraph (c) of this subsection or as added by the commissioner in
27 accordance with KRS 304.17A-280, but only to the extent that the condition

1 exceeds the numerical score or rating established pursuant to uniform
2 underwriting standards prescribed by the commissioner under paragraph (b) of
3 this subsection that account for the severity of the condition and the cost
4 associated with treating that condition.
5 (b) The commissioner by administrative regulation shall establish uniform
6 underwriting standards and a score or rating above which a condition is
7 considered to be high-cost by using:
8 1. Codes in the most recent version of the "International Classification of
9 Diseases" that correspond to the medical conditions in paragraph (c) of
10 this subsection and the costs for administering treatment for the
11 conditions represented by those codes; and
12 2. The most recent version of the questionnaire incorporated in a national
13 underwriting guide generally accepted in the insurance industry as
14 designated by the commissioner, the scoring scale for which shall be
15 established by the commissioner.
16 (c) The diagnosed medical conditions are: acquired immune deficiency syndrome
17 (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver,
18 coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia,
19 hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes,
20 leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis,
21 muscular dystrophy, myasthenia gravis, myotonia, open heart surgery,
22 Parkinson's disease, polycystic kidney, psychotic disorders, quadriplegia,
23 stroke, syringomyelia, and Wilson's disease;
24 (25) "Index rate" means, for each class of business as to a rating period, the arithmetic
25 average of the applicable base premium rate and the corresponding highest premium
26 rate;
27 (26) "Individual market" means the market for the health insurance coverage offered to

1 individuals other than in connection with a group health plan. The individual market
2 includes an association plan that is not employer related, issued to individuals on an
3 individually underwritten basis, other than an employer-organized association or a
4 bona fide association, that has been organized and is maintained in good faith for
5 purposes other than obtaining insurance for its members and that has a constitution
6 and bylaws;

7 (27) "Insurer" means any insurance company; health maintenance organization; self-
8 insurer or multiple employer welfare arrangement not exempt from state regulation
9 by ERISA; provider-sponsored integrated health delivery network; self-insured
10 employer-organized association, or nonprofit hospital, medical-surgical, dental, or
11 health service corporation authorized to transact health insurance business in
12 Kentucky;

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

19 (29) "Kentucky Access" has the meaning provided in KRS 304.17B-001~~[(17)]~~;

20 (30) "Large group" means:

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

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

23 (c) An employer-organized association that is a bona fide association as defined
24 in~~[subsection (5) of]~~ this section;

25 (31) "Managed care" means systems or techniques generally used by third-party payors
26 or their agents to affect access to and control payment for health care services and
27 that integrate the financing and delivery of appropriate health care services to

1 covered persons by arrangements with participating providers who are selected to
2 participate on the basis of explicit standards for furnishing a comprehensive set of
3 health care services and financial incentives for covered persons using the
4 participating providers and procedures provided for in the plan;
5 (32) "Market segment" means the portion of the market covering one (1) of the
6 following:
7 (a) Individual;
8 (b) Small group;
9 (c) Large group; or
10 (d) Association;
11 (33) "Participant" means any employee or former employee of an employer, or any
12 member or former member of an employee organization, who is or may become
13 eligible to receive a benefit of any type from an employee benefit plan which covers
14 employees of the employer or members of the organization, or whose beneficiaries
15 may be eligible to receive any benefit as established in Section 3(7) of ERISA;
16 (34) "Preventive services" means medical services for the early detection of disease that
17 are associated with substantial reduction in morbidity and mortality;
18 (35) "Provider network" means an affiliated group of varied health care providers that is
19 established to provide a continuum of health care services to individuals;
20 (36) "Provider-sponsored integrated health delivery network" means any provider-
21 sponsored integrated health delivery network created and qualified under KRS
22 304.17A-300 and KRS 304.17A-310;
23 (37) "Purchaser" means an individual, organization, employer, association, or the
24 Commonwealth that makes health benefit purchasing decisions on behalf of a group
25 of individuals;
26 (38) "Rating period" means the calendar period for which premium rates are in effect. A
27 rating period shall not be required to be a calendar year;

1 (39) "Restricted provider network" means a health benefit plan that conditions the
2 payment of benefits, in whole or in part, on the use of the providers that have
3 entered into a contractual arrangement with the insurer to provide health care
4 services to covered individuals;
5 (40) "Self-insured plan" means a group health insurance plan in which the sponsoring
6 organization assumes the financial risk of paying for covered services provided to
7 its enrollees;
8 (41) "Small employer" means, in connection with a group health plan with respect to a
9 calendar year and a plan year, an employer who employed an average of at least two
10 (2) but not more than fifty (50) employees on business days during the preceding
11 calendar year and who employs at least two (2) employees on the first day of the
12 plan year;
13 (42) "Small group" means:
14 (a) A small employer with two (2) to fifty (50) employees; or
15 (b) An affiliated group or association with two (2) to fifty (50) eligible members;
16 (43) "Standard benefit plan" means the plan identified in KRS 304.17A-250; and
17 (44) "Telehealth":
18 (a) Means the delivery of health care-related services by a health care provider
19 who is licensed in Kentucky to a patient or client through a face-to-face
20 encounter with access to real-time interactive audio and video technology or
21 store and forward services that are provided via asynchronous technologies as
22 the standard practice of care where images are sent to a specialist for
23 evaluation. The requirement for a face-to-face encounter shall be satisfied
24 with the use of asynchronous telecommunications technologies in which the
25 health care provider has access to the patient's or client's medical history prior
26 to the telehealth encounter;
27 (b) Shall not include the delivery of services through electronic mail, text chat,

1 facsimile, or standard audio-only telephone call; and
2 (c) Shall be delivered over a secure communications connection that complies
3 with the federal Health Insurance Portability and Accountability Act of 1996,
4 42 U.S.C. secs. 1320d to 1320d-9.
5 ➔Section 6. KRS 304.17A-741 is amended to read as follows:
6 When an audit of the records of a pharmacy is conducted by an auditing entity, it shall be
7 subject to the following conditions:
8 (1) The auditing entity shall give at least thirty (30) days' written notice to the pharmacy
9 prior to conducting the audit for each audit to be conducted;
10 (2) An audit performed by the auditing entity that involves clinical or professional
11 judgment shall be conducted in consultation with a pharmacist;
12 (3) A pharmacy may use the records of a hospital, physician, or other practitioner as
13 defined in KRS 217.015(35), or transmitted by any means of communication, for
14 purposes of validating pharmacy records with respect to orders or refills of a drug;
15 (4) An auditing entity shall not require a pharmacy to keep records for a period of time
16 longer than two (2) years, or as required by state or federal law or regulation;
17 (5) The recoupment of claims shall be based on the actual overpayment or
18 underpayment of claims**,** unless the pharmacy agrees to a settlement ***amount that is***
19 ***less than the determination made by the auditing entity.***[to the contrary] ***The***
20 ***auditing entity shall take into consideration any post-adjudication claims fees or***
21 ***recoupment when determining the claim recoupment amount. For claims where***
22 ***an ordered drug was dispensed to the patient, the claim recoupment amount shall***
23 ***not exceed the dispensing or professional fee paid on the claim***;
24 (6) A pharmacy shall be audited under the same standards and parameters as other
25 similarly situated pharmacies audited by the auditing entity;
26 (7) The period covered by the audit shall not exceed two (2) years from the date the
27 claim was submitted for payment except if a longer period is allowed by federal law

1 or if there is evidence of fraud;
2 (8) An audit shall not be scheduled during the first seven (7) calendar days of any
3 month, unless consented to by the pharmacy;
4 (9) A preliminary audit report shall be delivered to the pharmacy within one hundred
5 twenty (120) days after the exit interview;
6 (10) A final audit report shall be delivered to the pharmacy within six (6) months after
7 receipt of the preliminary audit report or after all appeals have been exhausted,
8 whichever is later;
9 (11) The auditing entity shall allow a pharmacy at least thirty (30) days following receipt
10 of the preliminary audit report to produce documentation to address any
11 discrepancies found during an audit;
12 (12) The final audit report shall provide claim-level detail of the amounts and reasons for
13 each claim recovery found due. If no amounts have been found due, the final audit
14 report shall so state;
15 (13) The auditing entity shall not receive payment based on the amount recovered in an
16 audit;
17 (14) The auditing entity shall conduct an exit interview at the close of the audit. The exit
18 interview shall be conducted at a time agreed to by the audited pharmacy. The
19 interview shall provide the audited pharmacy an opportunity to:
20 (a) Respond to questions from the auditing entity;
21 (b) Review and comment on the initial findings of the auditing entity; and
22 (c) Provide additional documentation to clarify the initial findings of the auditing
23 entity;
24 (15) If an audit results in the identification of any clerical or recordkeeping errors such as
25 typographical errors, scrivener's errors, omissions, or computer errors, the pharmacy
26 shall not be subject to recoupment of funds by the auditing entity unless the auditing
27 entity can provide proof of intent to commit fraud or the error results in an actual

1 overpayment to the pharmacy or the wrong medication being dispensed to the
2 patient. The pharmacy shall have the right to submit amended claims within thirty
3 (30) days of the discovery of an error to correct clerical or recordkeeping errors in
4 lieu of recoupment if the prescription was dispensed according to requirements set
5 forth in state or federal law;
6 (16) In the case of overpayment, the auditing entity may seek a refund or recoupment of
7 the overpayment in accordance with KRS 304.17A-712. The amount refunded or
8 recouped shall be limited to the amount paid to the pharmacy minus the amount that
9 should have been paid to the pharmacy absent the overpayment and shall not
10 include the dispensing fee if the correct medication was dispensed to the patient;
11 and
12 (17) Claims shall be paid pursuant to KRS 304.17A-702.
13 ➔Section 7. KRS 18A.225 (Effective July 1, 2019) is amended to read as follows:
14 (1) (a) The term "employee" for purposes of this section means:
15 1. Any person, including an elected public official, who is regularly
16 employed by any department, office, board, agency, or branch of state
17 government; or by a public postsecondary educational institution; or by
18 any city, urban-county, charter county, county, or consolidated local
19 government, whose legislative body has opted to participate in the state-
20 sponsored health insurance program pursuant to KRS 79.080; and who
21 is either a contributing member to any one (1) of the retirement systems
22 administered by the state, including but not limited to the Kentucky
23 Retirement Systems, Kentucky Teachers' Retirement System, the
24 Legislators' Retirement Plan, or the Judicial Retirement Plan; or is
25 receiving a contractual contribution from the state toward a retirement
26 plan; or, in the case of a public postsecondary education institution, is an
27 individual participating in an optional retirement plan authorized by

1 KRS 161.567;
2 2. Any certified or classified employee of a local board of education;
3 3. Any elected member of a local board of education;
4 4. Any person who is a present or future recipient of a retirement
5 allowance from the Kentucky Retirement Systems, Kentucky Teachers'
6 Retirement System, the Legislators' Retirement Plan, the Judicial
7 Retirement Plan, or the Kentucky Community and Technical College
8 System's optional retirement plan authorized by KRS 161.567, except
9 that a person who is receiving a retirement allowance and who is age
10 sixty-five (65) or older shall not be included, with the exception of
11 persons covered under KRS 61.702(4)(c), unless he or she is actively
12 employed pursuant to subparagraph 1. of this paragraph; and
13 5. Any eligible dependents and beneficiaries of participating employees
14 and retirees who are entitled to participate in the state-sponsored health
15 insurance program;
16 (b) The term "health benefit plan" for the purposes of this section means a health
17 benefit plan as defined in KRS 304.17A-005;
18 (c) The term "insurer" for the purposes of this section means an insurer as defined
19 in KRS 304.17A-005; and
20 (d) The term "managed care plan" for the purposes of this section means a
21 managed care plan as defined in KRS 304.17A-500.
22 (2) (a) The secretary of the Finance and Administration Cabinet, upon the
23 recommendation of the secretary of the Personnel Cabinet, shall procure, in
24 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,
25 from one (1) or more insurers authorized to do business in this state, a group
26 health benefit plan that may include but not be limited to health maintenance
27 organization (HMO), preferred provider organization (PPO), point of service

1 (POS), and exclusive provider organization (EPO) benefit plans encompassing
2 all or any class or classes of employees. With the exception of employers
3 governed by the provisions of KRS Chapters 16, 18A, and 151B, all
4 employers of any class of employees or former employees shall enter into a
5 contract with the Personnel Cabinet prior to including that group in the state
6 health insurance group. The contracts shall include but not be limited to
7 designating the entity responsible for filing any federal forms, adoption of
8 policies required for proper plan administration, acceptance of the contractual
9 provisions with health insurance carriers or third-party administrators, and
10 adoption of the payment and reimbursement methods necessary for efficient
11 administration of the health insurance program. Health insurance coverage
12 provided to state employees under this section shall, at a minimum, contain
13 the same benefits as provided under Kentucky Kare Standard as of January 1,
14 1994, and shall include a mail-order drug option as provided in subsection
15 ***(12)***[(13)] of this section. All employees and other persons for whom the
16 health care coverage is provided or made available shall annually be given an
17 option to elect health care coverage through a self-funded plan offered by the
18 Commonwealth or, if a self-funded plan is not available, from a list of
19 coverage options determined by the competitive bid process under the
20 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available
21 during annual open enrollment.
22 (b) The policy or policies shall be approved by the commissioner of insurance and
23 may contain the provisions the commissioner of insurance approves, whether
24 or not otherwise permitted by the insurance laws.
25 (c) Any carrier bidding to offer health care coverage to employees shall agree to
26 provide coverage to all members of the state group, including active
27 employees and retirees and their eligible covered dependents and

beneficiaries, within the county or counties specified in its bid. Except as provided in subsection ***(16)***[~~(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

1 mandates. If state self-insurance was available as a carrier option, the report
2 also shall provide a detailed financial analysis of the self-insurance fund
3 including but not limited to loss ratios, reserves, and reinsurance agreements.
4 (f) If any agency participating in the state-sponsored employee health insurance
5 program for its active employees terminates participation and there is a state
6 appropriation for the employer's contribution for active employees' health
7 insurance coverage, then neither the agency nor the employees shall receive
8 the state-funded contribution after termination from the state-sponsored
9 employee health insurance program.
10 (g) Any funds in flexible spending accounts that remain after all reimbursements
11 have been processed shall be transferred to the credit of the state-sponsored
12 health insurance plan's appropriation account.
13 (h) Each entity participating in the state-sponsored health insurance program shall
14 provide an amount at least equal to the state contribution rate for the employer
15 portion of the health insurance premium. For any participating entity that used
16 the state payroll system, the employer contribution amount shall be equal to
17 but not greater than the state contribution rate.
18 (3) The premiums may be paid by the policyholder:
19 (a) Wholly from funds contributed by the employee, by payroll deduction or
20 otherwise;
21 (b) Wholly from funds contributed by any department, board, agency, public
22 postsecondary education institution, or branch of state, city, urban-county,
23 charter county, county, or consolidated local government; or
24 (c) Partly from each, except that any premium due for health care coverage or
25 dental coverage, if any, in excess of the premium amount contributed by any
26 department, board, agency, postsecondary education institution, or branch of
27 state, city, urban-county, charter county, county, or consolidated local

1 government for any other health care coverage shall be paid by the employee.
2 (4) If an employee moves his place of residence or employment out of the service area
3 of an insurer offering a managed health care plan, under which he has elected
4 coverage, into either the service area of another managed health care plan or into an
5 area of the Commonwealth not within a managed health care plan service area, the
6 employee shall be given an option, at the time of the move or transfer, to change his
7 or her coverage to another health benefit plan.
8 (5) No payment of premium by any department, board, agency, public postsecondary
9 educational institution, or branch of state, city, urban-county, charter county,
10 county, or consolidated local government shall constitute compensation to an
11 insured employee for the purposes of any statute fixing or limiting the
12 compensation of such an employee. Any premium or other expense incurred by any
13 department, board, agency, public postsecondary educational institution, or branch
14 of state, city, urban-county, charter county, county, or consolidated local
15 government shall be considered a proper cost of administration.
16 (6) The policy or policies may contain the provisions with respect to the class or classes
17 of employees covered, amounts of insurance or coverage for designated classes or
18 groups of employees, policy options, terms of eligibility, and continuation of
19 insurance or coverage after retirement.
20 (7) Group rates under this section shall be made available to the disabled child of an
21 employee regardless of the child's age if the entire premium for the disabled child's
22 coverage is paid by the state employee. A child shall be considered disabled if he
23 has been determined to be eligible for federal Social Security disability benefits.
24 (8) The health care contract or contracts for employees shall be entered into for a period
25 of not less than one (1) year.
26 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of
27 State Health Insurance Subscribers to advise the secretary or his designee regarding

1 the state-sponsored health insurance program for employees. The secretary shall
2 appoint, from a list of names submitted by appointing authorities, members
3 representing school districts from each of the seven (7) Supreme Court districts,
4 members representing state government from each of the seven (7) Supreme Court
5 districts, two (2) members representing retirees under age sixty-five (65), one (1)
6 member representing local health departments, two (2) members representing the
7 Kentucky Teachers' Retirement System, and three (3) members at large. The
8 secretary shall also appoint two (2) members from a list of five (5) names submitted
9 by the Kentucky Education Association, two (2) members from a list of five (5)
10 names submitted by the largest state employee organization of nonschool state
11 employees, two (2) members from a list of five (5) names submitted by the
12 Kentucky Association of Counties, two (2) members from a list of five (5) names
13 submitted by the Kentucky League of Cities, and two (2) members from a list of
14 names consisting of five (5) names submitted by each state employee organization
15 that has two thousand (2,000) or more members on state payroll deduction. The
16 advisory committee shall be appointed in January of each year and shall meet
17 quarterly.
18 (10) Notwithstanding any other provision of law to the contrary, the policy or policies
19 provided to employees pursuant to this section shall not provide coverage for
20 obtaining or performing an abortion, nor shall any state funds be used for the
21 purpose of obtaining or performing an abortion on behalf of employees or their
22 dependents.
23 (11) ~~[Interruption of an established treatment regime with maintenance drugs shall be~~
24 ~~grounds for an insured to appeal a formulary change through the established appeal~~
25 ~~procedures approved by the Department of Insurance, if the physician supervising~~
26 ~~the treatment certifies that the change is not in the best interests of the patient.~~
27 ~~(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.

(12)[~~(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 ***that are related to reimbursement for services***, 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.

(13)[~~(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.~~

1 ~~(16) Any policy provided to state employees or their dependents pursuant to this section~~
2 ~~shall provide coverage for obtaining amino acid-based elemental formula pursuant~~
3 ~~to KRS 304.17A-258.~~
4 ~~(17)]~~ If a state employee's residence and place of employment are in the same county, and
5 if the hospital located within that county does not offer surgical services, intensive
6 care services, obstetrical services, level II neonatal services, diagnostic cardiac
7 catheterization services, and magnetic resonance imaging services, the employee
8 may select a plan available in a contiguous county that does provide those services,
9 and the state contribution for the plan shall be the amount available in the county
10 where the plan selected is located.
11 ***(14)***[~~(18)~~] If a state employee's residence and place of employment are each located in
12 counties in which the hospitals do not offer surgical services, intensive care
13 services, obstetrical services, level II neonatal services, diagnostic cardiac
14 catheterization services, and magnetic resonance imaging services, the employee
15 may select a plan available in a county contiguous to the county of residence that
16 does provide those services, and the state contribution for the plan shall be the
17 amount available in the county where the plan selected is located.
18 ***(15)***[~~(19)~~] The Personnel Cabinet is encouraged to study whether it is fair and reasonable
19 and in the best interests of the state group to allow any carrier bidding to offer
20 health care coverage under this section to submit bids that may vary county by
21 county or by larger geographic areas.
22 ***(16)***[~~(20)~~] Notwithstanding any other provision of this section, the bid for proposals for
23 health insurance coverage for calendar year 2004 shall include a bid scenario that
24 reflects the statewide rating structure provided in calendar year 2003 and a bid
25 scenario that allows for a regional rating structure that allows carriers to submit bids
26 that may vary by region for a given product offering as described in this subsection:
27 (a) The regional rating bid scenario shall not include a request for bid on a

1 statewide option;
2 (b) The Personnel Cabinet shall divide the state into geographical regions which
3 shall be the same as the partnership regions designated by the Department for
4 Medicaid Services for purposes of the Kentucky Health Care Partnership
5 Program established pursuant to 907 KAR 1:705;
6 (c) The request for proposal shall require a carrier's bid to include every county
7 within the region or regions for which the bid is submitted and include but not
8 be restricted to a preferred provider organization (PPO) option;
9 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the
10 carrier all of the counties included in its bid within the region. If the Personnel
11 Cabinet deems the bids submitted in accordance with this subsection to be in
12 the best interests of state employees in a region, the cabinet may award the
13 contract for that region to no more than two (2) carriers; and
14 (e) Nothing in this subsection shall prohibit the Personnel Cabinet from including
15 other requirements or criteria in the request for proposal.
16 ***(17)***[~~(21)~~] Any fully insured health benefit plan or self-insured plan issued or renewed on
17 or after ***the effective date of this Act***[~~July 12, 2006~~], ***and provided*** to public
18 employees pursuant to this section ***shall:***
19 ***(a) Provide that interruption of an established treatment regime with***
20 ***maintenance drugs shall be grounds for an insured to appeal a formulary***
21 ***change through the established appeal procedures approved by the***
22 ***Department of Insurance, if the physician supervising the treatment***
23 ***certifies that the change is not in the best interests of the patient;***
24 ***(b) Provide coverage meeting the requirements of:***
25 ***1. KRS 304.17A-132;***
26 ***2. KRS 304.17A-142; and***
27 ***3. KRS 304.17A-258;***

(c) Comply with:

1. KRS 304.17A-270 and 304.17A-525;

2. KRS 304.17A-600 to 304.17A-633;

3. KRS 205.593;

4. KRS 304.17A-700 to 304.17A-730;

5. KRS 304.14-135;

6. KRS 304.17A-580 and 304.17A-641;

7. KRS 304.99-123;

8. KRS 304.17A-138;

9. Section 4 of this Act; and

10. Administrative regulations promulgated pursuant to statutes listed in this paragraph and paragraph (b) of this subsection;

(d) If the plan utilizes a pharmacy benefit manager, ensure that the manager complies with Sections 1, 2, 3, and 4 of this Act; and

(e) If the plan~~[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 8. KRS 205.522 is amended to read as follows:

A managed care organization that provides Medicaid benefits pursuant to this chapter shall***:***

(1) Comply with the provisions of***:***

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

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

(c) KRS 304.17A-740 to 304.17A-743***; and***

(d) Section 4 of this Act; and

(2) Ensure that any pharmacy benefit manager working on its behalf complies with the provisions of Sections 1, 2, 3, and 4 of this Act.

➔Section 9. This Act takes effect on January 1, 2020.