AN ACT relating to consumer protection through regulation of pharmacy-related trade practices.

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

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

As used in this section and Sections 3 to 6 of this Act:

(1) "Health plan":

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

(b) Shall include but not be limited to a health benefit plan; and

(c) Shall not include a policy, certificate, contract, or plan that offers or provides Medicaid services under KRS Chapter 205;

(2) "Insurer":

(a) Means any of the following persons or entities that offer or issue a health plan:

1. An insurance company;

2. A health maintenance organization;

3. A limited health service organization;

4. A self-insurer, including a governmental plan, church plan, or multiple employer welfare arrangement;

5. A provider-sponsored integrated health delivery network;

6. A self-insured employer-organized association;

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

8. Any other third-party payor that is:

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

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

(b) Shall include any person or entity that has contracted with a state or federal agency to provide coverage in this state for pharmacy or pharmacist services, except persons or entities that have contracted to provide Medicaid services under KRS Chapter 205;

(3) "Pharmacy affiliate" means any pharmacy, including a specialty pharmacy:

(a) With which the pharmacy benefit manager shares common ownership, management, or control;

(b) Which is owned, managed, or controlled by any of the pharmacy benefit manager's management companies, parent companies, subsidiary companies, jointly held companies, or companies otherwise affiliated by a common owner, manager, or holding company;

(c) Which shares any common members on its board of directors with the pharmacy benefit manager; or

(d) Which shares managers in common with the pharmacy benefit manager;

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

(5) "Pharmacy or pharmacist services":

(a) Means any health care procedures, treatments within the scope of practice of a pharmacist, or services provided by a pharmacy or a pharmacist; and

(b) Shall include the provision of:

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

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

(6) "Rebate":

(a) Means a discount, price concession, or payment that is:

1. Based on utilization of a prescription drug; and

2. Paid after a claim for pharmacy or pharmacist services has been

adjudicated at a pharmacy; and

(b) Shall include, without limitation, incentives, disbursements, and reasonable estimates of a volume-based discount.

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

To the extent permitted under federal law:

(1) As used in this section:

(a) "Cost sharing"***:***

1. Means the cost to an~~[individual]~~ insured under a health plan***,*** according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the plan~~[, which may be subject to annual limitations on cost sharing, including those imposed under 42 U.S.C. secs. 18022(c) and 300gg-6(b)]~~, in order for ***the insured***~~[an individual]~~ to receive a specific health care service covered by the plan; ***and***

2. May be subject to annual limitations, including those imposed under 42 U.S.C. secs. 18022(c) and 300gg-6(b);

(b) "Generic alternative" means a drug that is designated to be therapeutically equivalent by the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, except that a drug shall not be considered a generic alternative until the drug is nationally available;

(c) "Health plan" ***has the same meaning as in Section 1 of this Act***~~[:~~

~~1. Means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services; and~~

~~2. Includes a health benefit plan as defined in KRS 304.17A-005]~~;

(d) ***"Income, payments, and financial benefits" has the same meaning as in***

Section 5 of this Act;

(e) "Insured" means any individual who is enrolled in a health plan and on whose behalf the insurer is obligated to pay for or provide ***pharmacy or pharmacist***~~[health care]~~ services;

(f)~~[(e)]~~ "Insurer" ***has the same meaning as in Section 1 of this Act***~~[includes:~~

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

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

(g)~~[(f)]~~ "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, government, or governmental subdivision or agency;

(h)~~[(g)]~~ "Pharmacy" includes:

1. A pharmacy, as defined in KRS Chapter 315;
2. A pharmacist, as defined in KRS Chapter 315; ***and***~~[or]~~
3. Any employee of a pharmacy or pharmacist;~~[and]~~

(i) "Pharmacy or pharmacist services" has the same meaning as in Section 1 of this Act; and

(j)~~[(h)]~~ "Pharmacy benefit manager" has the same meaning as in ***KRS 304.9-020***~~[KRS 304.17A-161]~~.

(2) ***Except as provided in subsection (4) of this section,***~~[To the extent permitted under federal law,]~~ an insurer***,***~~[issuing or renewing a health plan on or after January 1, 2022, or]~~ a pharmacy benefit manager, ***or any other administrator*** shall not:

(a) Require an insured~~[purchasing a prescription drug]~~ to***:***

1. Pay a cost-sharing amount ***for pharmacy or pharmacist services that exceeds the lesser of the following:***~~[greater than]~~

a. The amount the insured would pay for the ***services***~~[drug]~~ if he or

she were to purchase the ***services***~~[drug]~~ without coverage; ***or***

b. The cost-sharing amount charged to the insured for the services at the point of sale. At least one hundred percent (100%) of the income, payments, and financial benefits received, or to be received, in connection with the services shall be used to:

i. Reduce the cost-sharing amount charged to the insured for the services at the point of sale; and

ii. For any income, payments, and financial benefits remaining after the reductions required under subdivision i. of this subparagraph, reduce premiums charged by the health plan; or

2. a. Use a mail-order pharmaceutical distributor, including a mail-order pharmacy, in order to receive coverage under the plan.

b. Conduct prohibited under this subparagraph shall include but is not limited to requiring the use of a mail-order pharmaceutical distributor, including a mail-order pharmacy, to furnish a health care provider a prescription drug by the United States postal service or a common carrier for subsequent administration in a hospital, clinic, pharmacy, or infusion center;

(b) ***Impose upon an insured any cost-sharing requirement, fee, or other condition relating to pharmacy or pharmacist services:***

1. Received from a retail pharmacy or pharmacist that is greater, or more restrictive, than what would otherwise be imposed if the insured used a mail-order pharmaceutical distributor, including a mail-order pharmacy, if the retail pharmacy or pharmacist has agreed to accept reimbursement at no more than the amount that would have been reimbursed to the mail-order pharmaceutical distributer; or

2. That is not equally imposed upon all insureds in the same benefit category, class, or cost-sharing level under the health plan, unless otherwise required or permitted under this section;

(c) Exclude any cost-sharing amounts paid by an insured, or on behalf of an insured by another person, for a prescription drug, including any amount paid under paragraph (a)***1.a.*** of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply***:***

1. In the case of a prescription drug for which there is a generic alternative, unless the insured has obtained access to the brand prescription drug through prior authorization, a step therapy protocol, or the insurer's exceptions and appeals process***; or***

2. To any fully insured health benefit plan or self-insured plan provided to an employee under Section 14 of this Act;

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

(e)~~[(d)]~~ Impose a penalty on a pharmacy for complying with this section.

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

(4) ***If the application of any requirement of subsection (2) of this section would be the sole cause of a health plan's failure to qualify as a Health Savings Account-qualified High Deductible Health plan under 26 U.S.C. sec. 223, as amended, then the requirement shall not apply to that health plan until the minimum deductible under 26 U.S.C. sec. 223, as amended, is satisfied***~~[Subsection (2)(b) of this section shall not apply to any fully insured health benefit plan or self-insured plan provided to an employee under KRS 18A.225]~~.

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

To the extent permitted under federal law:

(1) (a) All pharmacy benefit managers that utilize a pharmacy network shall ensure that the network is reasonably adequate and accessible for the provision of pharmacy or pharmacist services under health plans.

(b) A reasonably adequate and accessible pharmacy network shall, at a minimum, offer:

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

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

(2) (a) All pharmacy benefit managers conducting business in this state shall file with the commissioner an annual report in the manner and form prescribed by the commissioner describing the pharmacy networks of the pharmacy benefit manager that are utilized for the provision of pharmacy or pharmacist services under a health plan.

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

(c) All information and data acquired by the department under this subsection that is generally recognized as confidential or proprietary shall not be subject to disclosure under KRS 61.870 to 61.884, except the department may publicly disclose aggregated information not descriptive of any readily

identifiable person or entity.

➔SECTION 4. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

To the extent permitted under federal law:

(1) As used in this section:

(a) "340B entity" means an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. sec. 256b, as amended, including its pharmacy or pharmacies, or any pharmacy or pharmacies contracted with the participating entity to dispense drugs purchased through the program;

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

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

2. Were not rendered in accordance with the prescriber's order, in which case only the amount paid for that portion of the prescription that was filled incorrectly or in excess of the prescriber's order may be deemed an actual overpayment. The amount denied, refunded, or recouped shall not include the dispensing fee paid to the pharmacy if the correct medication was dispensed to the patient;

(c) "Medication-assisted treatment prescription" means a prescription for a medication to treat a substance use disorder, including but not limited to buprenorphine and suboxone;

(d) "National drug code number" means the unique national drug code number that identifies a specific approved drug, its manufacturer, and its package presentation;

(e) "Net amount" means the amount paid to the pharmacy or pharmacist by

the pharmacy benefit manager less any fees, price concessions, and all other revenue passing from the pharmacy or pharmacist to the pharmacy benefit manager; and

(f) "Wholesale acquisition cost" means the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data.

(2) Every contract between a pharmacy or pharmacist and a pharmacy benefit manager for the provision of pharmacy or pharmacist services under a health plan, either directly or through a pharmacy services administration organization, shall comply with subsections (3) and (4) of this section.

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

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

(b) 1. Establish procedures for changing the contract, which shall comply with KRS 304.17A-235.

2. For purposes of implementing this paragraph, any changes to procedures set forth in the contract for dispute resolution, verifying drugs included on a formulary, or contract termination shall be considered material;

(c) Except as may otherwise be required under state or federal law, provide the pharmacy or pharmacist:

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

2. At least ninety (90) days' prior written notice of a nonrenewal of the

contract, sent in accordance with the notice required for proposed material changes under KRS 304.17A-235, which shall include the following:

a. The proposed effective date of the nonrenewal;

b. The name, business address, telephone number, and electronic mail address of a representative of the pharmacy benefit manager that can discuss the proposed nonrenewal; and

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

3. At least thirty (30) days' prior written notice of any notices to insureds covered under the health plan that the pharmacy has been or will be removed from the plan's provider network;

(d) Prohibit the pharmacy benefit manager from:

1. Reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement. This prohibition shall include, without limitation, creating, imposing, or establishing:

a. Direct or indirect remuneration fees;

b. Any effective rate, including but not limited to:

i. Generic effective rates;

ii. Dispensing effective rates; and

iii. Brand effective rates;

c. In-network fees;

d. Performance fees;

e. Pre-adjudication fees;

f. Post-adjudication fees; and

g. Any other mechanism that reduces, or aggregately reduces,

payment for pharmacy or pharmacist services;

2. Retroactively denying, reducing reimbursement for, or seeking any refunds or recoupments for a claim for pharmacy or pharmacist services, in whole or in part, from the pharmacy or pharmacist after returning a paid claim response as part of the adjudication of the claim, including claims for the cost of a medication or dispensed product and claims for services that are deemed ineligible for coverage, unless one (1) or more of the following occurred:

a. The original claim was submitted fraudulently; or

b. The pharmacy or pharmacist received an actual overpayment; and

3. Reimbursing the pharmacy or pharmacist for a prescription drug or other service at a net amount that is lower than the amount the pharmacy benefit manager reimburses itself or a pharmacy affiliate for the same prescription drug by national drug code number or service; and

(e) 1. Require reimbursement to the pharmacy or pharmacist for a prescription drug or other service:

a. i. At a net amount that is equal to or greater than the national average drug acquisition cost for the drug or service at the time the drug or service is administered, dispensed, or provided; or

ii. If the national average drug acquisition cost is not available for a prescription drug at the time the drug is administered or dispensed, at a net amount that is equal to or greater than the wholesale acquisition cost for the drug;

b. Plus a professional dispensing fee that is equal to or greater than

ten dollars and sixty-four cents ($10.64); and

c. i. If the prescription drug is a non-sterile prescription drug, an additional compounding fee that is equal to or greater than fifteen dollars ($15.00); or

ii. If the prescription drug is a sterile prescription drug that requires compounding as defined in KRS 315.010, an additional compounding fee that is equal to or greater than thirty dollars ($30.00).

2. Medication-assisted treatment prescriptions shall be exempt from any dispensing fee threshold established by the pharmacy benefit manager and a pharmacy or pharmacist shall receive a professional dispensing fee for each dispensing of a medication-assisted treatment prescription.

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

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

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

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

1. Requires special handling; and

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

(d) Prohibit, restrict, or limit the disclosure of information to the commissioner,

a state or federal law enforcement agency, or a state or federal regulatory agency;

(e) Except as otherwise required in this section, establish a standard or formula containing one (1) or more variables for reimbursement of pharmacy or pharmacist services that permits the pharmacy benefit manager, at its sole discretion, to change or determine the value of any variable;

(f) Prohibit a pharmacy or pharmacist from utilizing the United States postal service or a common carrier to deliver prescription drugs to patients;

(g) Require a pharmacy or pharmacist to enter a separate mail-order agreement in order to allow delivery of prescription drugs by the United States postal service or a common carrier;

(h) Require any type of identification of a drug as purchased by a 340B entity at the point of sale on a claim; or

(i) 1. Base reimbursement for a prescription drug on patient outcomes, scores, or metrics.

2. This paragraph shall not prohibit reimbursement for pharmacy care, including professional dispensing fees, from being based on patient outcomes, scores, or metrics if:

a. The patient outcomes, scores, or metrics are disclosed to, and agreed to by, the pharmacy or pharmacist in advance; and

b. Any professional dispensing fee reimbursement is equal to or greater than ten dollars sixty-four cents ($10.64).

(5) A pharmacy benefit manager providing pharmacy benefit management services on behalf of a health plan shall not:

(a) Discriminate against any pharmacy, including a 340B entity;

(b) Create, modify, implement, or establish, directly or indirectly, any fee not otherwise prohibited under this section relating to pharmacy or pharmacist

services on the pharmacy, pharmacist, or an insured without first seeking and obtaining written approval from the commissioner to do so;

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

1. Notice that the pharmacy benefit manager intends to reject the offer or application; and

2. The reason or reasons why the pharmacy benefit manager intends to reject the offer or application;

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

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

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

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

(6) Conduct prohibited by subsection (5)(a) of this section shall include but is not limited to:

(a) Discriminating against any pharmacy or pharmacist that is:

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

2. Willing to agree to, or accept, reasonable terms and conditions established by the pharmacy benefit manager for network participation;

(b) Reimbursing a 340B entity for a pharmacy-dispensed drug at an amount that is lower than the amount paid for the same drug by national drug code number to pharmacies that are not 340B entities;

(c) Assessing any pharmacy-related fee, chargeback, or other adjustment, including any fee, chargeback, or adjustment relating to pharmacy-dispensed drugs, upon a 340B entity that is not equally assessed on non-340B entities;

(d) Imposing limits, including quantity limits or refill frequency limits, on a pharmacy's access to medication that differ from those existing for a pharmacy affiliate;

(e) 1. Requiring, or incentivizing, an insured to receive pharmacy or pharmacist services from a pharmacy affiliate.

2. Conduct prohibited under this paragraph shall include the offer or implementation of a plan design that requires or incentivizes insureds to use pharmacy affiliates, including but not limited to:

a. Requiring or incentivizing an insured to obtain a specialty drug from a pharmacy affiliate;

b. Charging less cost sharing to insureds that use pharmacy affiliates than the pharmacy benefit manager charges to insureds that use nonaffiliated pharmacies; and

c. Providing any incentives for insureds that use pharmacy affiliates that are not provided for insureds that use nonaffiliated pharmacies.

3. This paragraph shall not be construed to prohibit:

a. Communications to insureds regarding pharmacy networks and prices if the communication is accurate and includes information about all eligible nonaffiliated pharmacies; or

b. Requiring an insured to utilize a pharmacy network that may include pharmacy affiliates in order to receive coverage under the plan, or providing financial incentives for utilizing that network, if the pharmacy benefit manager complies with subsection (5)(a) of this section and Section 3 of this Act; and

(f) 1. Not providing equal access and incentives to all pharmacies within the pharmacy benefit manager's network.

2. Conduct prohibited under this paragraph shall include but is not limited to interfering with an insured's right to choose the insured's network pharmacy of choice. For purposes of this subparagraph, interfering includes inducement, steering, offering financial or other incentives, or imposing a penalty.

➔SECTION 5. A NEW SECTION OF SUBTITLE 17A KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

To the extent permitted under federal law:

(1) As used in this section:

(a) 1. "Income, payments, and financial benefits" means any rebates, other pricing discounts, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other benefits received, or to be received, from a manufacturer or other party by an insurer, a pharmacy benefit manager, or an administrator that are related to:

a. Pharmacy or pharmacist services provided to insureds; or

b. Pharmacy benefit management services provided on behalf of a health plan or insurer.

2. For purposes of this paragraph, "other party" means any person, business, or entity, except:

a. A pharmacy benefit manager;

b. An insurer, which shall include its administrator; or

c. An insured under a health plan;

(b) "Pass-through pricing" means a payment model for pharmacy benefit management services that:

1. Limits payment by an insurer, or its administrator, to the pharmacy benefit manager to:

a. The actual ingredient costs paid by the pharmacy benefit manager for prescription drugs provided under the insurer's or administrator's contract or other arrangement;

b. Dispensing fees paid by the pharmacy benefit manager to pharmacies or pharmacists for the provision of pharmacy or pharmacist services under the insurer's or administrator's contract or other arrangement;

c. Any other amounts paid by the pharmacy benefit manager to pharmacies or pharmacists for the provision of pharmacy or pharmacist services under the insurer's or administrator's contract or other arrangement; and

d. An administrative fee;

2. Requires the pharmacy benefit manager to pass through any income, payments, and financial benefits received, or to be received, by the pharmacy benefit manager:

a. To reduce cost sharing, in accordance with subsection (2)(a)1.b.i. of Section 2 of this Act; and

b. To the insurer, for any portion remaining after the reductions required under subsection (2)(a)1.b.i. of Section 2 of this Act; and

3. Requires the pharmacy benefit manager to:

a. Fully disclose to each insurer:

i. All ingredient costs paid by the pharmacy benefit manager for prescription drugs provided under the insurer's, or its administrator's, contract or other arrangement;

ii. All ingredient costs, dispensing fees, and other payments made by the pharmacy benefit manager to any pharmacy or pharmacist in connection with the insurer's, or its administrator's, contract or other arrangement;

iii. The sources, amounts, and payee of all income, payments, and financial benefits referred to in subparagraph 2. of this paragraph; and

iv. Its payment model for charging an administrative fee to the insurer or its administrator; and

b. Not utilize any form of spread pricing in any contract or other arrangement to provide pharmacy benefit management services on behalf of a health plan; and

(c) "Spread pricing" means any technique by which a pharmacy benefit manager charges or claims an amount from an insurer, or its administrator, for payment of pharmacy or pharmacist services, including payment for a prescription drug, that is different than the amount the pharmacy benefit manager pays to the pharmacy or pharmacist that provided the services.

(2) An insurer contracting, either directly or through an administrator, with a pharmacy benefit manager to provide pharmacy benefit management services on behalf of a health plan shall:

(a) Prior to entering into the contract, require the pharmacy benefit manager to disclose any activity, policy, practice, contract, including any national

pharmacy contract, or agreement that may directly or indirectly present a conflict of interest in the pharmacy benefit manager's relationship with the insurer; and

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

(3) Every contract between an insurer or its administrator and a pharmacy benefit manager for the provision of pharmacy benefit management services on behalf of a health plan shall:

(a) Require the use of pass-through pricing; and

(b) Provide that the pharmacy benefit manager shall:

1. Owe a fiduciary duty to the insurer; and

2. Comply with the requirements of this chapter.

(4) (a) Each insurer shall:

1. Pass through any income, payments, and financial benefits received, or to be received, by the insurer or its administrator in accordance with subsection (2)(a)1.b. of Section 2 of this Act; and

2. Report, annually, to the commissioner the aggregate amount of income, payments, and financial benefits received by the insurer, either directly or in accordance with a contract or other arrangement that utilizes pass-through pricing, that are not used to reduce cost sharing in accordance with subsection (2)(a)1.b.i. of Section 2 of this Act.

(b) The commissioner shall consider the information in the report required under this subsection when reviewing any premium rates charged under health plans.

(5) Administrators, including insurers acting as an administrator, shall not offer any

incentive or discount to a health plan or other third-party payor for the use of a pharmacy benefit manager that is owned by or otherwise associated with the administrator.

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

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

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

(b) Pharmacy benefit managers.

(2) The advisory council shall consist of six (6) members, which shall include the commissioner as a nonvoting member. The commissioner shall serve as chair of the advisory council. Except as provided in subsection (3) of this section, the remaining members shall serve two (2) year terms, be appointed by the Governor, with the advice of the commissioner, and shall be constituted as follows:

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

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

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

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

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

(3) The original appointments under subsection (2) of this section shall be staggered so that three (3) of the appointments shall expire at three (3) years from the dates of initial appointment.

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

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

(6) The advisory council shall be a budgetary unit of the department, which shall:

(a) Pay all of the advisory council's necessary operating expenses; and

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

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

➔SECTION 7. A NEW SECTION OF SUBTITLE 99 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

In addition to any other remedies, penalties, or damages available under common law or statute, the commissioner may order reimbursement to any person who has incurred a monetary loss as a result of a violation of Section 2, 3, 4, or 5 of this Act.

➔Section 8. KRS 304.9-054 is amended to read as follows:

(1) ***As used in this section:***

(a) "Income, payments, and financial benefits" has the same meaning as in

Section 5 of this Act; and

(b) "Rebate" has the same meaning as in Section 1 of this Act.

(2) (a) Upon receipt of a completed application, evidence of financial responsibility, and fee, the commissioner shall make a review of each applicant ***for a pharmacy benefit manager license.***~~[and]~~

(b) The commissioner shall issue a license if the applicant is qualified in accordance with this section and KRS 304.9-053.

(c)~~[(2)]~~ The commissioner may require ***and obtain*** additional information or submissions from applicants~~[and may obtain any documents or information]~~***,*** ***as*** reasonably necessary to verify the information contained in the application.

(3) ***(a)*** The commissioner may suspend, revoke, or refuse to issue or renew any ***pharmacy benefit manager*** license in accordance with KRS 304.9-440.

(b)~~[(4)]~~ The commissioner may make determinations on the length of suspension for an applicant, not to exceed twenty-four (24) months. However, the licensee may have the alternative, subject to the approval of the commissioner, to pay in lieu of part or all of the days of any suspension period a sum of one thousand dollars ($1,000) per day not to exceed two hundred fifty thousand dollars ($250,000).

(c)~~[(5)]~~ If the commissioner's denial or revocation is sustained after a hearing in accordance with KRS Chapter 13B, an applicant may make a new application not earlier than one (1) full year after the date on which a denial or revocation was sustained.

(4)~~[(6)]~~ ***(a) The commissioner may promulgate administrative regulations to implement, enforce, or aid in the effectuation of any provision of this chapter applicable to pharmacy benefit managers.***

(b) The administrative regulations permitted under paragraph (a) of this subsection include but are not limited to administrative regulations that

establish:

1. Prohibited practices, including market conduct practices, of pharmacy benefit managers;

2. Data reporting requirements; and

3. Specifications for the sharing of information with pharmacy affiliates.~~[The department shall promulgate administrative regulations in accordance with KRS Chapter 13A to implement and enforce the provisions of this section and KRS 205.647, 304.9-053, 304.9-055, and 304.17A-162.]~~

(c) The ***commissioner shall promulgate*** administrative regulations ***that***~~[shall]~~ specify the contents ***and format*** of the application form and any other form***,*** ***disclosure,*** or report required ***or permitted under this section***.

(5)~~[(7)]~~ ***(a) For contracts referenced in subsection (3) of Section 5 of this Act, a pharmacy benefit manager shall report to the commissioner, on a quarterly basis, for each insurer:***

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

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

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

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

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

pharmacy, product, and goods and services.

(b) In addition to the reporting required under paragraph (a) of this subsection and under Section 3 of this Act, pharmacy benefit managers providing pharmacy benefit management services on behalf of a health plan shall submit an annual report to the commissioner.

(c) To the extent permitted under federal law, the annual report required under paragraph (b) of this subsection shall include but is not be limited to:

1. A list of the health plans that are administered by the pharmacy benefit manager; and

2. For health plan contracts entered during the immediately preceding calendar year:

a. The aggregate amount of income, payments, and financial benefits that the pharmacy benefit manager received for all insurers and each insurer; and

b. The aggregate amount of rebates that the pharmacy benefit manager received for all insurers.

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

(6) (a) Except as provided in paragraph (b) of this subsection, pharmacy benefit managers shall file a quarterly report with the commissioner of any drugs that are reimbursed by the pharmacy benefit manager at ten percent (10%) or more:

1. Below the national average drug acquisition cost at the time the drug is administered or dispensed; and

2. Above the national average drug acquisition cost at the time the drug is administered or dispensed.

(b) Paragraph (a) of this subsection shall not apply to drugs that:

1. Are dispensed pursuant to 42 U.S.C. sec. 256b; or

2. Do not appear on the national average drug acquisition cost list.

(c) For each drug in the report, the pharmacy benefit manager shall include:

1. The month the drug was dispensed;

2. The quantity of the drug dispensed;

3. The amount the pharmacy was reimbursed;

4. Whether the dispensing pharmacy was a pharmacy affiliate;

5. Whether the drug was dispensed under a governmental plan; and

6. The average national average drug acquisition cost for the month the drug was dispensed.

(d) A copy of the report required under this subsection shall also be publicly available on the pharmacy benefit manager's Web site for a period of at least twenty-four (24) months.

(7) (a) The department may impose a fee upon pharmacy benefit managers**,** in addition to a license fee**,** to cover the costs of implementation and enforcement of ***KRS 205.647 and any provision of this chapter applicable to pharmacy benefit managers, including but not limited to*** this section and KRS ~~[205.647,]~~304.9-053, 304.9-055, and 304.17A-162**.**

(b) The fees permitted under paragraph (a) of this subsection shall include~~[, including]~~ fees to cover the cost of:

1.~~[(a)]~~ Salaries and benefits paid to the personnel of the department engaged in the enforcement;

2.~~[(b)]~~ Reasonable technology costs related to the enforcement process. Technology costs shall include the actual cost of software and hardware

utilized in the enforcement process and the cost of training personnel in the proper use of the software or hardware; and

3.~~[(c)]~~ Reasonable education and training costs incurred by the state to maintain the proficiency and competence of the enforcing personnel.

➔Section 9. KRS 304.17A-708 is amended to read as follows:

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

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

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

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

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

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

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

(e) Notwithstanding the provisions of this subsection, a pharmacy benefit manager shall not retroactively deny reimbursement in violation of Section 4 of this Act.

➔Section 10. KRS 304.17A-712 is amended to read as follows:

(1) Except as provided in subsection (2) of this section, if an insurer determines that payment was made for services rendered to an individual who was not eligible for coverage or that payment was made for services not covered by a covered person's health benefit plan, the insurer shall give written notice to the provider and:

(a) ~~[(1)]~~ Request a refund from the provider; or

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

(2) A pharmacy benefit manager shall not request a refund or make a recoupment in violation of Section 4 of this Act.

➔Section 11. KRS 304.17A-714 is amended to read as follows:

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

(a) Request a refund from the provider; or

(b) Indicate on the notice that, within thirty (30) calendar days from the postmark

date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.

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

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

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

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

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

(a) The amount of the recoupment;

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

(c) Patient identification number; and

(d) Date of service.

(7) Notwithstanding the provisions of this section, a pharmacy benefit manager shall not collect any amounts in violation of Section 4 of this Act.

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

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

➔SECTION 13. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

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

➔Section 14. 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, County Employees Retirement System, 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, County Employees Retirement System, 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 or her place of residence or employment out of the service area of an insurer offering a managed health care plan, under which he or she 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 or she 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 the secretary's 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 June 29, 2021,]~~ to public employees pursuant to this section shall comply with:

(a) KRS 304.12-237;

(b) 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) ***KRS 304.17A-148;***

(k) Section 2 of this Act;

(l) Section 5 of this Act; and

(m) 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 January 1, 2022, to public employees pursuant to this section shall comply with KRS 304.17A-148.]~~

➔Section 15. KRS 367.828 is amended to read as follows:

(1) As used in this section, "health discount plan" means any card, program, device, or mechanism that is not insurance that purports to offer discounts or access to discounts from a health care provider without recourse to the health discount plan.

(2) No person shall sell, market, promote, advertise, or otherwise distribute a health discount plan unless:

(a) The health discount plan clearly states in bold and prominent type on all cards or other purchasing devices, promotional materials, and advertising that the

discounts are not insurance;

(b) The discounts are specifically authorized by an individual and separate contract with each health care provider listed in conjunction with the health discount plan;~~[and]~~

(c) The discounts or the range of discounts advertised or offered by the plan are clearly and conspicuously disclosed to the consumer***; and***

(d) For health discount plans that purport to offer discounts or access to discounts on prescription drugs, the plan does not:

1. Utilize the same identifying information used by an insurer under a health insurance policy or plan, including but not limited to policy numbers, group numbers, or member identifications; or

2. Seek, or contract for, the payment of any refunds, recoupments, or fees from a pharmacy or pharmacist in connection with a consumer's transaction after the transaction has been completed.

(3) The provisions of subsection (2) of this section do not apply to the following:

(a) A customer discount or membership card issued by a retailer for use in its own facility; or

(b) Any card, program, device, or mechanism that is not insurance and which is administered by a health insurer authorized to transact the business of insurance in this state***, if the card, program, device, or mechanism does not purport to offer discounts or access to discounts on prescription drugs***.

(4) A violation of this section shall be deemed an unfair, false, misleading, or deceptive act or practice in the conduct of trade or commerce in violation of KRS 367.170. All of the remedies, powers, and duties delegated to the Attorney General by KRS 367.190 to 367.300 and penalties pertaining to acts and practices declared unlawful under KRS 367.170 shall be applied to acts and practices in violation of this section.

➔Section 16. Sections 2 and 3 of this Act shall apply to health plans issued or renewed on or after January 1, 2023.

➔Section 17. Sections 4 and 5 of this Act shall apply to contracts issued, delivered, entered, renewed, extended, or amended on or after January 1, 2023.

➔Section 18. If any provision of this Act, or this Act's application to any person or circumstance, is held invalid, the invalidity shall not affect other provisions or applications of the Act, which shall be given effect without the invalid provision or application, and to this end the provisions and applications of this Act are severable.

➔Section 19. The commissioner of insurance shall promulgate administrative regulations to implement the provisions of this Act on or before January 1, 2023.

➔Section 20. Sections 1 to 17 of this Act take effect on January 1, 2023.