AN ACT relating to prescription drugs.

WHEREAS, citizens of Kentucky frequently rely on state-regulated insurers to secure access to the prescription medications needed to protect their health; and

WHEREAS, commercial insurance plans increasingly require patients to bear significant out-of-pocket costs for their prescription medications; and

WHEREAS, high out-of-pocket costs for prescription medications impact the ability of patients to start new and necessary treatments and to stay adherent with current medications; and

WHEREAS, high or unpredictable cost-sharing requirements are a main driver of elevated out-of-pocket costs and allow insurers to capture discounts and price concessions that are intended to benefit patients at the pharmacy counter; and

WHEREAS, insurers unfairly increase cost-sharing burdens on patients by refusing to count third-party assistance toward patients' cost-sharing contributions, and the burdens of high or unpredictable cost-sharing requirements are borne disproportionately by patients with chronic or debilitating conditions; and

WHEREAS, restrictions are needed on the ability of insurers and their intermediaries to use unfair cost-sharing designs to retain rebates and price concessions that instead should be directly passed on to the patient as cost savings; and

WHEREAS, patients need equitable and accessible health coverage that does not impose unfair cost-sharing burdens upon them;

NOW, THEREFORE,

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

➔Section 1. 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***, 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 an individual to receive a specific health care service covered by the plan;

(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":

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) "Insured" means any individual who is enrolled in a health plan and on whose behalf the insurer is obligated to pay for or provide health care services;

(e) "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;

(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;

(g)~~[(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

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

(2) ***To the extent permitted under federal law,*** an insurer issuing or renewing a health ~~[benefit]~~plan on or after ***the effective date of this Act***~~[January 1, 2019]~~, or pharmacy benefit manager**,** shall not:

(a) Require an insured purchasing a prescription drug to pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage~~[under a health benefit plan]~~;

(b) ***Exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person, including any amount paid under paragraph (a) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply in the case of a prescription drug for which there is a generic alternative, unless:***

1. The prescriber determines that the brand prescription drug is medically necessary; or

2. 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;

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

(d)~~[(c)]~~ 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 pursuant to this section for a prescription drug.

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

➔Section 2. The Department of Insurance may promulgate administrative regulations necessary to carry out Section 1 of this Act.

➔Section 3. This Act takes effect January 1, 2022.