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 ***a*** 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 for a prescription drug, 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.