

1 AN ACT relating to pharmacy or pharmacist services.

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

3 ➔Section 1. KRS 304.17A-164 is amended to read as follows:

4 (1) As used in this section:

5 (a) "Cost sharing":

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

13 **2.** ***May be subject to annual limitations, including those imposed under***  
14 **42 U.S.C. secs. 18022(c) and 300gg-6(b);**

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

20 (c) "Health plan" ***has the same meaning as in Section 2 of this Act***~~:~~

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

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

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

- 1 (e) "Insurer":  
 2 **1. Has the same meaning as in Section 2 of this Act; and**  
 3 **2. Includes:**  
 4 1. ~~An insurer offering a health plan providing coverage for pharmacy~~  
 5 ~~benefits; or~~  
 6 2. ~~any other administrator of pharmacy benefits under a health plan;~~  
 7 (f) "Person" means a natural person, corporation, mutual company,  
 8 unincorporated association, partnership, joint venture, limited liability  
 9 company, trust, estate, foundation, nonprofit corporation, unincorporated  
 10 organization, government, or governmental subdivision or agency;  
 11 (g) "Pharmacy" includes:  
 12 1. A pharmacy, as defined in KRS Chapter 315;  
 13 2. A pharmacist, as defined in KRS Chapter 315; ~~and~~  
 14 3. Any employee of a pharmacy or pharmacist; ~~and~~  
 15 (h) "Pharmacy benefit manager" has the same meaning as in KRS 304.9-020,  
 16 except for purposes of this section, the term does not include a pharmacy  
 17 benefit manager that is contracted by and acting under the direction of any  
 18 hospital or health system that provides a self-insured plan if the hospital or  
 19 health system owns a pharmacy; and~~[304.17A-161]~~  
 20 (i) **"Pharmacy or pharmacist services" has the same meaning as in Section 2**  
 21 **of this Act.**  
 22 (2) To the extent permitted under federal law, an insurer ~~issuing or renewing a health~~  
 23 ~~plan on or after January 1, 2022,~~ or a pharmacy benefit manager~~,~~ shall not:  
 24 (a) Require an insured~~[purchasing a prescription drug]~~ to:  
 25 **1. Pay a cost-sharing amount for pharmacy or pharmacist services** greater  
 26 than the amount the insured would pay for the ~~services~~~~[drug]~~ if he or she  
 27 were to purchase the ~~services~~~~[drug]~~ without coverage; **or**

- 1           2. a. Use a mail-order pharmaceutical distributor, including a mail-  
 2                                   order pharmacy, in order to receive coverage under the plan.  
 3           b. Conduct prohibited under this subparagraph includes but is not  
 4                                   limited to requiring the use of a mail-order pharmaceutical  
 5                                   distributor, including a mail-order pharmacy, to furnish a health  
 6                                   care provider a prescription drug by the United States Postal  
 7                                   Service or a common carrier for subsequent administration in a  
 8                                   hospital, clinic, pharmacy, or infusion center;
- 9       (b) Impose upon an insured any cost-sharing requirement, fee, or other  
 10           condition relating to:
- 11           1. Pharmacy or pharmacist services received from a retail pharmacy or  
 12                                   pharmacist that is greater, or more restrictive, than what would  
 13                                   otherwise be imposed if:
- 14                                   a. The insured used a mail-order pharmaceutical distributor,  
 15                                   including a mail-order pharmacy; and
- 16                                   b. The retail pharmacy or pharmacist has agreed to accept  
 17                                   reimbursement at no more than the amount that would have  
 18                                   been reimbursed to the mail-order pharmaceutical distributor;
- 19           2. Prescription drugs furnished by a health care provider for  
 20                                   administration in a hospital, clinic, pharmacy, or infusion center that  
 21                                   is greater, or more restrictive, than what would otherwise be imposed  
 22                                   if a mail-order pharmaceutical distributor, including a mail-order  
 23                                   pharmacy, furnished the prescription drugs to the health care  
 24                                   provider; or
- 25           3. Pharmacy or pharmacist services that is not equally imposed upon all  
 26                                   insureds in the same benefit category, class, or cost-sharing level  
 27                                   under the health plan, unless otherwise required or permitted under

1 **this section;**

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

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

11 2. To any fully insured health benefit plan or self-insured plan provided  
12 to an employee under Section 13 of this Act;

13 ~~(d)~~(e) Prohibit a pharmacy from discussing any information under subsection  
14 (3) of this section; or

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

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

19 ~~[(4) Subsection (2)(b) of this section shall not apply to any fully insured health benefit~~  
20 ~~plan or self-insured plan provided to an employee under KRS 18A.225.]~~

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

23 **As used in Sections 2 to 5 of this Act:**

24 **(1) "Health plan":**

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

1 (b) Includes a health benefit plan; and

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

4 (2) "Insurer":

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

7 1. An insurance company;

8 2. A health maintenance organization;

9 3. A limited health service organization;

10 4. A self-insurer, including a governmental plan, church plan, or  
 11 multiple employer welfare arrangement, except any hospital or health  
 12 system that provides a self-insured plan if the hospital or health  
 13 system owns a pharmacy;

14 5. A provider-sponsored integrated health delivery network;

15 6. A self-insured employer-organized association;

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

18 8. Any other third-party payor that is:

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

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

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

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

27 (a) With which the pharmacy benefit manager shares common ownership,

1 management, or control;

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

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

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

9 (4) "Pharmacy benefit manager" has the same meaning as in KRS 304.9-020, except  
 10 for purposes of Sections 3, 4, and 5 of this Act, the term does not include a  
 11 pharmacy benefit manager that is contracted by and acting under the direction of  
 12 any hospital or health system that provides a self-insured plan if the hospital or  
 13 health system owns a pharmacy;

14 (5) "Pharmacy or pharmacist services":

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

17 (b) Includes the provision of:

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

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

20 (6) "Rebate":

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

22 1. Based on utilization of a prescription drug; and

23 2. Paid after a claim for pharmacy or pharmacist services has been  
 24 adjudicated at a pharmacy; and

25 (b) Includes, without limitation, incentives, disbursements, and reasonable  
 26 estimates of a volume-based discount.

27 ➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304

1 IS CREATED TO READ AS FOLLOWS:

2 To the extent permitted under federal law:

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

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

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

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

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

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

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

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

3 *To the extent permitted under federal law:*

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

5           *(a) "Actual overpayment" means the portion of any amount paid for pharmacy*  
6           *or pharmacist services that:*

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

9           *2. Was erroneously paid because the services were not rendered in*  
10           *accordance with the prescriber's order, in which case only the amount*  
11           *paid for that portion of the prescription that was filled incorrectly or in*  
12           *excess of the prescriber's order may be deemed an actual*  
13           *overpayment. The amount denied, refunded, or recouped shall not*  
14           *include the dispensing fee paid to the pharmacy if the correct*  
15           *medication was dispensed to the patient;*

16           *(b) "Covered entity" means a covered entity participating in the federal 340B*  
17           *drug pricing program, as described in 42 U.S.C. sec. 256b, as amended;*

18           *(c) "Medication-assisted treatment prescription" means a prescription for a*  
19           *medication containing buprenorphine to treat a substance use disorder;*

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

23           *(e) "Net amount" means the amount paid to the pharmacy or pharmacist by*  
24           *the pharmacy benefit manager less any fees, price concessions, and all*  
25           *other revenue passing from the pharmacy or pharmacist to the pharmacy*  
26           *benefit manager;*

27 *(2) Every contract between a pharmacy or pharmacist and a pharmacy benefit*



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

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

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

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

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

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

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

18 2. At least ninety (90) days' prior written notice of a nonrenewal of the  
19 contract, sent in accordance with the notice required for proposed  
20 material changes under KRS 304.17A-235, which shall include the  
21 following:

22 a. The proposed effective date of the nonrenewal;

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

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

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

4            (d) Prohibit the pharmacy benefit manager from:

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

9            a. Direct or indirect remuneration fees;

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

11           i. Generic effective rates;

12           ii. Dispensing effective rates; and

13           iii. Brand effective rates;

14           c. In-network fees;

15           d. Performance fees;

16           e. Pre-adjudication fees;

17           f. Post-adjudication fees; and

18           g. Any other mechanism that reduces, or aggregately reduces,  
 19           payment for pharmacy or pharmacist services;

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

27           a. The original claim was submitted fraudulently; or

- 1                   **b. The pharmacy or pharmacist received an actual overpayment;**  
2                                   **and**  
3                   **3. Reimbursing the pharmacy or pharmacist for a prescription drug or**  
4                                   **other service at a net amount that is lower than the amount the**  
5                                   **pharmacy benefit manager reimburses itself or a pharmacy affiliate**  
6                                   **for the same prescription drug by national drug code number or**  
7                                   **service; and**  
8                   **(e) Require that medication-assisted treatment prescriptions be exempt from**  
9                                   **any dispensing fee threshold established by the pharmacy benefit manager**  
10                                   **and that pharmacies or pharmacists receive a professional dispensing fee**  
11                                   **for each dispensing of a medication-assisted treatment prescription;**  
12                   **(4) A contract referenced in subsection (2) of this section shall not:**  
13                                   **(a) Release the pharmacy benefit manager from the obligation to make any**  
14                                   **payments owed to the pharmacy or pharmacist for pharmacy or pharmacist**  
15                                   **services rendered prior to the termination of the pharmacy or pharmacist**  
16                                   **from a pharmacy network;**  
17                                   **(b) Require pharmacy accreditation standards or certification requirements**  
18                                   **inconsistent with, more stringent than, or in addition to Kentucky Board of**  
19                                   **Pharmacy standards or requirements;**  
20                                   **(c) Designate a prescription drug as a "specialty drug" unless the drug is a**  
21                                   **limited distribution prescription drug that:**  
22                                   **1. Requires special handling; and**  
23                                   **2. Is not commonly carried at retail pharmacies or oncology clinics or**  
24                                   **practices;**  
25                                   **(d) Prohibit, restrict, or limit the disclosure of information to the commissioner,**  
26                                   **a state or federal law enforcement agency, or a state or federal regulatory**  
27                                   **agency;**

- 1 (e) Except as otherwise required in this section, establish a standard or formula  
 2 containing one (1) or more variables for reimbursement of pharmacy or  
 3 pharmacist services that permits the pharmacy benefit manager, at its sole  
 4 discretion, to change or determine the value of any variable;
- 5 (f) Prohibit a pharmacy or pharmacist from utilizing the United States Postal  
 6 Service or a common carrier to deliver prescription drugs to patients;
- 7 (g) Require a pharmacy or pharmacist to enter a separate mail-order  
 8 agreement in order to allow delivery of prescription drugs by the United  
 9 States Postal Service or a common carrier; or
- 10 (h) 1. Base reimbursement for a prescription drug on patient outcomes,  
 11 scores, or metrics.
- 12 2. This paragraph shall not prohibit reimbursement for pharmacy care,  
 13 including professional dispensing fees, from being based on patient  
 14 outcomes, scores, or metrics if the patient outcomes, scores, or metrics  
 15 are disclosed to, and agreed to by, the pharmacy or pharmacist in  
 16 advance;
- 17 (5) A pharmacy benefit manager providing pharmacy benefit management services  
 18 on behalf of a health plan shall not:
- 19 (a) Discriminate against any pharmacy, including a pharmacy owned by or  
 20 contracted with a covered entity;
- 21 (b) Create, modify, implement, or establish, directly or indirectly, any fee not  
 22 otherwise prohibited under this section relating to pharmacy or pharmacist  
 23 services on the pharmacy, pharmacist, or an insured without first seeking  
 24 and obtaining written approval from the commissioner to do so;
- 25 (c) Reject offers or applications, including any pre-applications, to contract for  
 26 the provision of pharmacy or pharmacist services under the health plan  
 27 made by a pharmacy or pharmacist that, if required, has been credentialed,

1 unless the following notice is provided, in writing and by telephone, to the  
 2 pharmacy or pharmacist at least fifteen (15) calendar days prior to the  
 3 rejection:

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

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

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

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

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

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

18 (6) Conduct prohibited by subsection (5)(a) of this section includes but is not limited  
 19 to:

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

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

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

25 (b) Reimbursing a covered entity, including any pharmacy owned by or  
 26 contracted with the covered entity, for a pharmacy-dispensed drug at an  
 27 amount that is lower than the amount paid for the same drug by national

1 drug code number to an entity that is not a covered entity or a pharmacy  
 2 that is not owned by or contracted with a covered entity;

3 (c) Assessing any pharmacy-related fee, chargeback, or other adjustment,  
 4 including any fee, chargeback, or adjustment relating to pharmacy-  
 5 dispensed drugs, upon a covered entity, including any pharmacy owned by  
 6 or contracted with a covered entity, that is not equally assessed on an entity  
 7 that is not a covered entity or a pharmacy that is not owned by or contracted  
 8 with a covered entity;

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

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

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

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

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

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

25 3. This paragraph shall not be construed to prohibit:

26 a. Communications to insureds regarding pharmacy networks and  
 27 prices if the communication is accurate and includes

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

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

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

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

16 To the extent permitted under federal law:

17 (1) For contracts between an insurer or its administrator and a pharmacy benefit  
 18 manager for the provision of pharmacy benefit management services on behalf of  
 19 a health plan:

20 (a) Prior to entering into the contract, the pharmacy benefit manager shall  
 21 disclose to the insurer any activity, policy, practice, contract, including any  
 22 national pharmacy contract, or agreement that may directly or indirectly  
 23 present a conflict of interest in the pharmacy benefit manager's relationship  
 24 with the insurer;

25 (b) The insurer shall monitor the activities carried out in this state on its behalf  
 26 by the pharmacy benefit manager to ensure compliance with the  
 27 requirements of this chapter; and

1 (c) The contract shall require the pharmacy benefit manager to:

2 1. Owe a fiduciary duty to the insurer; and

3 2. Comply with the requirements of this chapter; and

4 (2) Administrators, including insurers acting as an administrator, shall not offer any  
5 incentive or discount to a health plan or other third-party payor for the use of a  
6 pharmacy benefit manager that is owned by or otherwise associated with the  
7 administrator.

8 ➔SECTION 6. A NEW SECTION OF SUBTITLE 99 OF KRS CHAPTER 304  
9 IS CREATED TO READ AS FOLLOWS:

10 In addition to any other remedies, penalties, or damages available under common law  
11 or statute, the commissioner may order reimbursement to any person who has incurred  
12 a monetary loss as a result of a violation of Section 1, 3, 4, or 5 of this Act.

13 ➔Section 7. KRS 304.9-054 is amended to read as follows:

14 (1) As used in this section, "rebate" has the same meaning as in Section 2 of this  
15 Act.

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

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

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

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

26 ~~(b)(4)~~ The commissioner may make determinations on the length of suspension  
27 for an applicant, not to exceed twenty-four (24) months. However, the



1 licensee may have the alternative, subject to the approval of the commissioner,  
 2 to pay in lieu of part or all of the days of any suspension period a sum of one  
 3 thousand dollars (\$1,000) per day not to exceed two hundred fifty thousand  
 4 dollars (\$250,000).

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

9 ~~(4)~~~~(6)~~ (a) The commissioner may promulgate administrative regulations to  
 10 implement, enforce, or aid in the effectuation of any provision of this  
 11 chapter applicable to pharmacy benefit managers.

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

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

17 2. Data reporting requirements; and

18 3. Specifications for the sharing of information with pharmacy

19 affiliates.~~[The department shall promulgate administrative regulations in~~  
 20 ~~accordance with KRS Chapter 13A to implement and enforce the~~  
 21 ~~provisions of this section and KRS 205.647, 304.9-053, 304.9-055, and~~  
 22 ~~304.17A-162.]~~

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

26 ~~(5)~~~~(7)~~ (a) For contracts referenced in subsection (1) of Section 5 of this Act, a  
 27 pharmacy benefit manager shall report to the commissioner, on a quarterly

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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 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, 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

1 subject to disclosure under KRS 61.870 to 61.884, except the department  
 2 may publicly disclose aggregated information not descriptive of any readily  
 3 identifiable person or entity.

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

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

11 ~~1.{(a)}~~ Salaries and benefits paid to the personnel of the department  
 12 engaged in the enforcement;

13 ~~2.{(b)}~~ Reasonable technology costs related to the enforcement process.  
 14 Technology costs shall include the actual cost of software and hardware  
 15 utilized in the enforcement process and the cost of training personnel in  
 16 the proper use of the software or hardware; and

17 ~~3.{(c)}~~ Reasonable education and training costs incurred by the state to  
 18 maintain the proficiency and competence of the enforcing personnel.

19 ➔Section 8. KRS 304.17A-708 is amended to read as follows:

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

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

- 1 (3) (a) Except in cases of fraud, an insurer may only retroactively deny  
 2 reimbursement to a provider during the twenty-four (24) month period after  
 3 the date that the insurer paid the claim submitted by the provider.
- 4 (b) An insurer that retroactively denies reimbursement to a provider under this  
 5 section shall give the provider a written or electronic statement specifying the  
 6 basis for the retroactive denial.
- 7 (c) If the retroactive denial of reimbursement results from coordination of  
 8 benefits, the written statement shall specify the name and address of the entity  
 9 acknowledging responsibility for payment of the denied claim.
- 10 (d) If an insurer retroactively denies reimbursement for services as a result of  
 11 coordination of benefits with another insurer, the provider shall have twelve  
 12 (12) months from the date that the provider received notice of the denial,  
 13 unless the insurer that retroactively denied reimbursement permits a longer  
 14 period, to submit a claim for reimbursement for the service to the insurer, the  
 15 medical assistance program, or the Medicare program responsible for  
 16 payment.
- 17 **(e) Notwithstanding the provisions of this subsection, a pharmacy benefit**  
 18 **manager shall not retroactively deny reimbursement in violation of Section**  
 19 **4 of this Act.**

20 ➔Section 9. KRS 304.17A-712 is amended to read as follows:

- 21 **(1) Except as provided in subsection (2) of this section,** if an insurer determines that  
 22 payment was made for services rendered to an individual who was not eligible for  
 23 coverage or that payment was made for services not covered by a covered person's  
 24 health benefit plan, the insurer shall give written notice to the provider and:
- 25 **(a)**~~(1)~~ Request a refund from the provider; or
- 26 **(b)**~~(2)~~ Make a recoupment of the overpayment from the provider in accordance  
 27 with KRS 304.17A-714.

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

3 ➔Section 10. KRS 304.17A-714 is amended to read as follows:

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

12 The insurer shall either:

- 13 (a) Request a refund from the provider; or  
 14 (b) Indicate on the notice that, within thirty (30) calendar days from the postmark  
 15 date or electronic delivery date of the insurer's notice, if the insurer does not  
 16 receive a notice of provider dispute in accordance with subsection (2) of this  
 17 section, the amount of the overpayment will be recouped from future  
 18 payments.
- 19 (2) If a provider disagrees with the amount of the overpayment, the provider shall  
 20 within thirty (30) calendar days from the postmark date or the electronic delivery  
 21 date of the insurer's written notice dispute the amount of the overpayment by  
 22 submitting additional information to the insurer.
- 23 (3) If a provider files a dispute in accordance with subsection (2) of this section, no  
 24 recoupment shall be made until the dispute is resolved. If a provider does not  
 25 dispute the amount of the overpayment and does not provide a refund as required in  
 26 subsection (2) of this section, the insurer may recoup the amount due from future  
 27 payments.

- 1 (4) All disputes submitted by providers pursuant to subsection (2) of this section shall  
 2 be processed in accordance and completed within thirty (30) days with the insurer's  
 3 provider appeals process.
- 4 (5) An insurer may recover an overpayment resulting from an error in the payment rate  
 5 or method by requesting a refund from the provider or making a recoupment of the  
 6 overpayment from the provider, subject to the provisions of subsection (6) of this  
 7 section. A provider may dispute such recoupment in accordance with the provisions  
 8 contained in KRS 304.17A-708.
- 9 (6) If an insurer chooses to collect an overpayment made to a provider through a  
 10 recoupment against future provider payments, the insurer shall, within twenty-four  
 11 (24) months from the date that the insurer paid the claim, and at the actual time of  
 12 recoupment give the provider written or electronic documentation that specifies:
- 13 (a) The amount of the recoupment;  
 14 (b) The covered person's name to whom the recoupment applies;  
 15 (c) Patient identification number; and  
 16 (d) Date of service.

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

19 ➔SECTION 11. A NEW SECTION OF SUBTITLE 17C OF KRS CHAPTER  
 20 304 IS CREATED TO READ AS FOLLOWS:

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

23 ➔SECTION 12. A NEW SECTION OF SUBTITLE 38A OF KRS CHAPTER  
 24 304 IS CREATED TO READ AS FOLLOWS:

25 **A limited health service organization shall comply with Sections 1 and 5 of this Act.**

26 ➔Section 13. KRS 18A.225 is amended to read as follows:

- 27 (1) (a) The term "employee" for purposes of this section means:

- 1           1. Any person, including an elected public official, who is regularly  
2           employed by any department, office, board, agency, or branch of state  
3           government; or by a public postsecondary educational institution; or by  
4           any city, urban-county, charter county, county, or consolidated local  
5           government, whose legislative body has opted to participate in the state-  
6           sponsored health insurance program pursuant to KRS 79.080; and who  
7           is either a contributing member to any one (1) of the retirement systems  
8           administered by the state, including but not limited to the Kentucky  
9           Retirement Systems, County Employees Retirement System, Kentucky  
10          Teachers' Retirement System, the Legislators' Retirement Plan, or the  
11          Judicial Retirement Plan; or is receiving a contractual contribution from  
12          the state toward a retirement plan; or, in the case of a public  
13          postsecondary education institution, is an individual participating in an  
14          optional retirement plan authorized by KRS 161.567; or is eligible to  
15          participate in a retirement plan established by an employer who ceases  
16          participating in the Kentucky Employees Retirement System pursuant to  
17          KRS 61.522 whose employees participated in the health insurance plans  
18          administered by the Personnel Cabinet prior to the employer's effective  
19          cessation date in the Kentucky Employees Retirement System;
- 20          2. Any certified or classified employee of a local board of education;
- 21          3. Any elected member of a local board of education;
- 22          4. Any person who is a present or future recipient of a retirement  
23          allowance from the Kentucky Retirement Systems, County Employees  
24          Retirement System, Kentucky Teachers' Retirement System, the  
25          Legislators' Retirement Plan, the Judicial Retirement Plan, or the  
26          Kentucky Community and Technical College System's optional  
27          retirement plan authorized by KRS 161.567, except that a person who is

1 receiving a retirement allowance and who is age sixty-five (65) or older  
 2 shall not be included, with the exception of persons covered under KRS  
 3 61.702(4)(c), unless he or she is actively employed pursuant to  
 4 subparagraph 1. of this paragraph; and

5 5. Any eligible dependents and beneficiaries of participating employees  
 6 and retirees who are entitled to participate in the state-sponsored health  
 7 insurance program;

8 (b) The term "health benefit plan" for the purposes of this section means a health  
 9 benefit plan as defined in KRS 304.17A-005;

10 (c) The term "insurer" for the purposes of this section means an insurer as defined  
 11 in KRS 304.17A-005; and

12 (d) The term "managed care plan" for the purposes of this section means a  
 13 managed care plan as defined in KRS 304.17A-500.

14 (2) (a) The secretary of the Finance and Administration Cabinet, upon the  
 15 recommendation of the secretary of the Personnel Cabinet, shall procure, in  
 16 compliance with the provisions of KRS 45A.080, 45A.085, and 45A.090,  
 17 from one (1) or more insurers authorized to do business in this state, a group  
 18 health benefit plan that may include but not be limited to health maintenance  
 19 organization (HMO), preferred provider organization (PPO), point of service  
 20 (POS), and exclusive provider organization (EPO) benefit plans encompassing  
 21 all or any class or classes of employees. With the exception of employers  
 22 governed by the provisions of KRS Chapters 16, 18A, and 151B, all  
 23 employers of any class of employees or former employees shall enter into a  
 24 contract with the Personnel Cabinet prior to including that group in the state  
 25 health insurance group. The contracts shall include but not be limited to  
 26 designating the entity responsible for filing any federal forms, adoption of  
 27 policies required for proper plan administration, acceptance of the contractual



1 provisions with health insurance carriers or third-party administrators, and  
2 adoption of the payment and reimbursement methods necessary for efficient  
3 administration of the health insurance program. Health insurance coverage  
4 provided to state employees under this section shall, at a minimum, contain  
5 the same benefits as provided under Kentucky Kare Standard as of January 1,  
6 1994, and shall include a mail-order drug option as provided in subsection  
7 (13) of this section. All employees and other persons for whom the health care  
8 coverage is provided or made available shall annually be given an option to  
9 elect health care coverage through a self-funded plan offered by the  
10 Commonwealth or, if a self-funded plan is not available, from a list of  
11 coverage options determined by the competitive bid process under the  
12 provisions of KRS 45A.080, 45A.085, and 45A.090 and made available  
13 during annual open enrollment.

14 (b) The policy or policies shall be approved by the commissioner of insurance and  
15 may contain the provisions the commissioner of insurance approves, whether  
16 or not otherwise permitted by the insurance laws.

17 (c) Any carrier bidding to offer health care coverage to employees shall agree to  
18 provide coverage to all members of the state group, including active  
19 employees and retirees and their eligible covered dependents and  
20 beneficiaries, within the county or counties specified in its bid. Except as  
21 provided in subsection (20) of this section, any carrier bidding to offer health  
22 care coverage to employees shall also agree to rate all employees as a single  
23 entity, except for those retirees whose former employers insure their active  
24 employees outside the state-sponsored health insurance program.

25 (d) Any carrier bidding to offer health care coverage to employees shall agree to  
26 provide enrollment, claims, and utilization data to the Commonwealth in a  
27 format specified by the Personnel Cabinet with the understanding that the data

1 shall be owned by the Commonwealth; to provide data in an electronic form  
2 and within a time frame specified by the Personnel Cabinet; and to be subject  
3 to penalties for noncompliance with data reporting requirements as specified  
4 by the Personnel Cabinet. The Personnel Cabinet shall take strict precautions  
5 to protect the confidentiality of each individual employee; however,  
6 confidentiality assertions shall not relieve a carrier from the requirement of  
7 providing stipulated data to the Commonwealth.

8 (e) The Personnel Cabinet shall develop the necessary techniques and capabilities  
9 for timely analysis of data received from carriers and, to the extent possible,  
10 provide in the request-for-proposal specifics relating to data requirements,  
11 electronic reporting, and penalties for noncompliance. The Commonwealth  
12 shall own the enrollment, claims, and utilization data provided by each carrier  
13 and shall develop methods to protect the confidentiality of the individual. The  
14 Personnel Cabinet shall include in the October annual report submitted  
15 pursuant to the provisions of KRS 18A.226 to the Governor, the General  
16 Assembly, and the Chief Justice of the Supreme Court, an analysis of the  
17 financial stability of the program, which shall include but not be limited to  
18 loss ratios, methods of risk adjustment, measurements of carrier quality of  
19 service, prescription coverage and cost management, and statutorily required  
20 mandates. If state self-insurance was available as a carrier option, the report  
21 also shall provide a detailed financial analysis of the self-insurance fund  
22 including but not limited to loss ratios, reserves, and reinsurance agreements.

23 (f) If any agency participating in the state-sponsored employee health insurance  
24 program for its active employees terminates participation and there is a state  
25 appropriation for the employer's contribution for active employees' health  
26 insurance coverage, then neither the agency nor the employees shall receive  
27 the state-funded contribution after termination from the state-sponsored

- 1           employee health insurance program.
- 2           (g) Any funds in flexible spending accounts that remain after all reimbursements  
3           have been processed shall be transferred to the credit of the state-sponsored  
4           health insurance plan's appropriation account.
- 5           (h) Each entity participating in the state-sponsored health insurance program shall  
6           provide an amount at least equal to the state contribution rate for the employer  
7           portion of the health insurance premium. For any participating entity that used  
8           the state payroll system, the employer contribution amount shall be equal to  
9           but not greater than the state contribution rate.
- 10       (3) The premiums may be paid by the policyholder:
- 11           (a) Wholly from funds contributed by the employee, by payroll deduction or  
12           otherwise;
- 13           (b) Wholly from funds contributed by any department, board, agency, public  
14           postsecondary education institution, or branch of state, city, urban-county,  
15           charter county, county, or consolidated local government; or
- 16           (c) Partly from each, except that any premium due for health care coverage or  
17           dental coverage, if any, in excess of the premium amount contributed by any  
18           department, board, agency, postsecondary education institution, or branch of  
19           state, city, urban-county, charter county, county, or consolidated local  
20           government for any other health care coverage shall be paid by the employee.
- 21       (4) If an employee moves his or her place of residence or employment out of the service  
22           area of an insurer offering a managed health care plan, under which he or she has  
23           elected coverage, into either the service area of another managed health care plan or  
24           into an area of the Commonwealth not within a managed health care plan service  
25           area, the employee shall be given an option, at the time of the move or transfer, to  
26           change his or her coverage to another health benefit plan.
- 27       (5) No payment of premium by any department, board, agency, public postsecondary

1 educational institution, or branch of state, city, urban-county, charter county,  
2 county, or consolidated local government shall constitute compensation to an  
3 insured employee for the purposes of any statute fixing or limiting the  
4 compensation of such an employee. Any premium or other expense incurred by any  
5 department, board, agency, public postsecondary educational institution, or branch  
6 of state, city, urban-county, charter county, county, or consolidated local  
7 government shall be considered a proper cost of administration.

8 (6) The policy or policies may contain the provisions with respect to the class or classes  
9 of employees covered, amounts of insurance or coverage for designated classes or  
10 groups of employees, policy options, terms of eligibility, and continuation of  
11 insurance or coverage after retirement.

12 (7) Group rates under this section shall be made available to the disabled child of an  
13 employee regardless of the child's age if the entire premium for the disabled child's  
14 coverage is paid by the state employee. A child shall be considered disabled if he or  
15 she has been determined to be eligible for federal Social Security disability benefits.

16 (8) The health care contract or contracts for employees shall be entered into for a period  
17 of not less than one (1) year.

18 (9) The secretary shall appoint thirty-two (32) persons to an Advisory Committee of  
19 State Health Insurance Subscribers to advise the secretary or the secretary's designee  
20 regarding the state-sponsored health insurance program for employees. The  
21 secretary shall appoint, from a list of names submitted by appointing authorities,  
22 members representing school districts from each of the seven (7) Supreme Court  
23 districts, members representing state government from each of the seven (7)  
24 Supreme Court districts, two (2) members representing retirees under age sixty-five  
25 (65), one (1) member representing local health departments, two (2) members  
26 representing the Kentucky Teachers' Retirement System, and three (3) members at  
27 large. The secretary shall also appoint two (2) members from a list of five (5) names

1 submitted by the Kentucky Education Association, two (2) members from a list of  
2 five (5) names submitted by the largest state employee organization of nonschool  
3 state employees, two (2) members from a list of five (5) names submitted by the  
4 Kentucky Association of Counties, two (2) members from a list of five (5) names  
5 submitted by the Kentucky League of Cities, and two (2) members from a list of  
6 names consisting of five (5) names submitted by each state employee organization  
7 that has two thousand (2,000) or more members on state payroll deduction. The  
8 advisory committee shall be appointed in January of each year and shall meet  
9 quarterly.

10 (10) Notwithstanding any other provision of law to the contrary, the policy or policies  
11 provided to employees pursuant to this section shall not provide coverage for  
12 obtaining or performing an abortion, nor shall any state funds be used for the  
13 purpose of obtaining or performing an abortion on behalf of employees or their  
14 dependents.

15 (11) Interruption of an established treatment regime with maintenance drugs shall be  
16 grounds for an insured to appeal a formulary change through the established appeal  
17 procedures approved by the Department of Insurance, if the physician supervising  
18 the treatment certifies that the change is not in the best interests of the patient.

19 (12) Any employee who is eligible for and elects to participate in the state health  
20 insurance program as a retiree, or the spouse or beneficiary of a retiree, under any  
21 one (1) of the state-sponsored retirement systems shall not be eligible to receive the  
22 state health insurance contribution toward health care coverage as a result of any  
23 other employment for which there is a public employer contribution. This does not  
24 preclude a retiree and an active employee spouse from using both contributions to  
25 the extent needed for purchase of one (1) state sponsored health insurance policy for  
26 that plan year.

27 (13) (a) The policies of health insurance coverage procured under subsection (2) of

1           this section shall include a mail-order drug option for maintenance drugs for  
2           state employees. Maintenance drugs may be dispensed by mail order in  
3           accordance with Kentucky law.

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

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

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

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

19       (16) Any policy provided to state employees or their dependents pursuant to this section  
20          shall provide coverage for obtaining amino acid-based elemental formula pursuant  
21          to KRS 304.17A-258.

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

1 where the plan selected is located.

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

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

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

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

20 (b) The Personnel Cabinet shall divide the state into geographical regions which  
21 shall be the same as the partnership regions designated by the Department for  
22 Medicaid Services for purposes of the Kentucky Health Care Partnership  
23 Program established pursuant to 907 KAR 1:705;

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

27 (d) If the Personnel Cabinet accepts a carrier's bid, the cabinet shall award the

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

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

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

14 (22) Any fully insured health benefit plan or self-insured plan issued or renewed ~~on or~~  
 15 ~~after June 29, 2021,~~ to public employees pursuant to this section shall comply with:

- 16 (a) KRS 304.12-237;
- 17 (b) KRS 304.17A-270 and 304.17A-525;
- 18 (c) KRS 304.17A-600 to 304.17A-633;
- 19 (d) KRS 205.593;
- 20 (e) KRS 304.17A-700 to 304.17A-730;
- 21 (f) KRS 304.14-135;
- 22 (g) KRS 304.17A-580 and 304.17A-641;
- 23 (h) KRS 304.99-123;
- 24 (i) KRS 304.17A-138; ~~and~~
- 25 (j) **KRS 304.17A-148;**
- 26 **(k) Section 1 of this Act;**
- 27 **(l) Section 5 of this Act; and**



1        **(m)** Administrative regulations promulgated pursuant to statutes listed in this  
2        subsection.

3        ~~[(23) Any fully insured health benefit plan or self-insured plan issued or renewed on or  
4        after January 1, 2022, to public employees pursuant to this section shall comply  
5        with KRS 304.17A-148.]~~

6        ➔SECTION 14. A NEW SECTION OF KRS CHAPTER 365 IS CREATED TO  
7        READ AS FOLLOWS:

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

9        **(a) "Pharmacy or pharmacist services" has the same meaning as in Section 2  
10        of this Act; and**

11        **(b) "Pharmacy services administration organization" means an entity that  
12        provides a pharmacy or pharmacist with administrative, contracting, or  
13        payment services relating to the provision of pharmacy or pharmacist  
14        services under any health insurance policy, health plan, or other contract  
15        that provides coverage in this state for pharmacy or pharmacist services.**

16        **(2) When contracting on behalf of one (1) or more pharmacies or pharmacists with a  
17        pharmacy benefit manager, insurer, or other third-party payor, or providing any  
18        other services on behalf of one (1) or more pharmacies or pharmacists, the  
19        pharmacy services administration organization shall owe a fiduciary duty to the  
20        pharmacies or pharmacists.**

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

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

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

27        (a) The health discount plan clearly states in bold and prominent type on all cards

1 or other purchasing devices, promotional materials, and advertising that the  
2 discounts are not insurance;

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

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

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

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

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

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

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

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

23 (4) A violation of this section shall be deemed an unfair, false, misleading, or deceptive  
24 act or practice in the conduct of trade or commerce in violation of KRS 367.170.  
25 All of the remedies, powers, and duties delegated to the Attorney General by KRS  
26 367.190 to 367.300 and penalties pertaining to acts and practices declared unlawful  
27 under KRS 367.170 shall be applied to acts and practices in violation of this

1 section.

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

4 ➔Section 17. Sections 4, 5, and 14 of this Act shall apply to contracts issued,  
5 delivered, entered, renewed, extended, or amended on or after January 1, 2023.

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

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

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