AN ACT relating to cost sharing for prescription drugs.

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:

(1) As used in this section:

(a) "Cost sharing" 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;

(b) "Health plan":

1. Means any state-regulated policy, certificate, contract, or plan that offers or provides coverage in this state, by direct payment, reimbursement, or otherwise, for prescription drugs; and

2. Includes but is not limited to a health benefit plan;

(c) "Level of coverage" means, as applicable, the bronze, silver, gold, or platinum level of coverage described in 42 U.S.C. sec. 18022, as amended;

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

(e) "Prescription drug":

1. Has the same meaning as in KRS 315.010; and

2. Includes specialty drugs; and

(f) "Rating area" means the rating area established under 42 U.S.C. sec. 300-gg, as amended.

(2) Except as provided in subsection (4) of this section:

(a) Every insurer that offers a health plan in the individual market shall limit an insured's cost sharing for prescription drugs under the plan to no more than the following for up to a thirty (30) day supply of any single drug:

1. For plans that provide a silver, gold, or platinum level of coverage, one hundred dollars ($100) per month; and

2. For plans that provide a bronze level of coverage, one hundred fifty dollars ($150) per month;

(b) Every insurer that offers a health plan in the small group market shall ensure that the plan complies with paragraph (a) of this subsection; and

(c) If an insurer offers more than one (1) health plan in the individual market or the small group market, or both the individual market and the small group market, the insurer shall ensure that at least fifty percent (50%) of the plans offered in each market, rating area, and in each of the bronze, silver, gold, and platinum levels of coverage comply with the requirements of paragraph (a) of this subsection.

(3) A pharmacy benefit manager that acts on behalf of an insurer or health plan subject to this section shall comply with the requirements of this section.

(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.

(5) All health plans subject to this section shall be:

(a) Clearly and appropriately named in a manner that aids the consumer during the plan selection process; and

(b) Marketed in the same manner as other plans offered by the insurer.

(6) (a) This section shall not be construed to limit coverage:

1. Provided under a policy, certificate, contract, or plan; or

2. Required under any other law.

(b) In the case of a conflict between this section and any other law, this section shall control unless application of this section would result in a reduction of coverage or benefits for any insured.

(7) The commissioner shall promulgate any administrative regulations necessary to enforce this section.

➔Section 2. This Act applies to health plans offered on or after the effective date of this Act.

➔Section 3. This Act takes effect on January 1, 2024.