

304.17A-595 Definitions for section -- Requirements for contract for provision of pharmacy services -- Minimum reimbursements -- Administrative regulations.

- (1) As used in this section:
 - (a) "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. Was erroneously paid because the services 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;
 - (b) "Ambulatory pharmacy" means a pharmacy that:
 1. Is open to the general public; and
 2. Dispenses outpatient prescription drugs;
 - (c) "National average drug acquisition cost" means the national average drug acquisition cost, or NADAC, for a prescription drug or other service that is:
 1. Determined by a survey of retail pharmacies; and
 2. Published by the federal Centers for Medicare and Medicaid Services;
 - (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 insurer, pharmacy benefit manager, or other administrator less any fees, price concessions, and all other revenue passing from the pharmacy or pharmacist to the insurer, pharmacy benefit manager, or other administrator; 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) To the extent permitted under federal law, every contract between a pharmacy or pharmacist and an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits for the provision of pharmacy or pharmacist services under a health plan, either directly or through a pharmacy services administration organization or group purchasing organization, shall:
 - (a) Outline the terms and conditions for the provision of pharmacy or pharmacist services;
 - (b) Prohibit the insurer, pharmacy benefit manager, or other administrator 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 direct or indirect remuneration fees, generic effective rates, dispensing effective rates, brand effective rates, any other effective rates, in-network fees, performance fees, point-of-sale fees, retroactive fees, pre-adjudication fees, post-adjudication fees, and 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 recouplements 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 pharmacy or pharmacist 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;
 3. Reimbursing the pharmacy or pharmacist for a prescription drug or other service at a net amount that is lower than the amount the insurer, pharmacy benefit manager, or other administrator reimburses itself or a pharmacy affiliate for the same:
 - a. Prescription drug by national drug code number; or
 - b. Service;
 4. Collecting cost sharing from a pharmacy or pharmacist that was provided to the pharmacy or pharmacist by an insured for the provision of pharmacy or pharmacist services under the health plan; and
 5. Designating a prescription drug as a specialty drug unless the drug is a limited distribution drug that:
 - a. Requires special handling; and
 - b. Is not commonly carried at retail pharmacies or oncology clinics or practices; and
- (c) Notwithstanding any other law, provide the following minimum reimbursements to the pharmacy or pharmacist for each prescription drug or other service provided by the pharmacy or pharmacist:
1. a. Except as provided in subdivision b. of this subparagraph, reimbursement for the cost of the drug or other service at an amount that is not less than:
 - i. 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 at the time a drug is administered or dispensed, the wholesale acquisition cost for the drug at the time the drug is administered or dispensed.

- b. The minimum reimbursement for the cost of a drug or other service required under this subparagraph shall not apply to a pharmacy permitted under KRS Chapter 315 with a designated pharmacy type of "retail chain" on file with the Kentucky Board of Pharmacy, or a pharmacist practicing at such a pharmacy, until a determination by the commissioner under subparagraph 2.a. of this paragraph has taken effect.
 - c. For purposes of complying with this subparagraph, the insurer, pharmacy benefit manager, or other administrator shall utilize the most recently published monthly national average drug acquisition cost as a point of reference for the ingredient drug product component of a pharmacy's or pharmacist's reimbursement for drugs appearing on the national average drug acquisition cost list; and
- 2.
- a. Except as provided in subdivision b. of this subparagraph, for health plan years beginning on or after January 1, 2027, reimbursement for a professional dispensing fee that is not less than the average cost to dispense a prescription drug in an ambulatory pharmacy located in Kentucky, as determined by the commissioner in an administrative regulation promulgated in accordance with KRS Chapter 13A.
 - b.
 - i. The minimum dispensing fee required under subdivision a. of this subparagraph shall not apply to a mail-order pharmaceutical distributor, including a mail-order pharmacy.
 - ii. For health plan years beginning prior to January 1, 2027, and for any future health plan years for which a determination by the commissioner under subdivision a. of this subparagraph has not taken effect, the minimum dispensing fee for a pharmacy permitted under KRS Chapter 315 with a designated pharmacy type of "retail independent" on file with the Kentucky Board of Pharmacy, or a pharmacist practicing at such a pharmacy, shall be not less than ten dollars and sixty-four cents (\$10.64).
 - c. In acquiring data for, and making, the determination required under subdivision a. of this subparagraph, the commissioner shall:
 - i. Promulgate an administrative regulation in accordance with KRS Chapter 13A that establishes the data elements to be collected by the Kentucky Board of Pharmacy under KRS 315.038;
 - ii. Conduct a study of the dispensing data submitted to the commissioner by the Kentucky Board of Pharmacy in accordance with KRS 315.038;
 - iii. Repeat the study every two (2) years to obtain updated information;
 - iv. Adjust the determination every two (2) years as appropriate

based upon the results of each study; and

- v. Comply with all requirements of KRS 315.038.
- d. In carrying out his or her duties under this subparagraph, the commissioner shall cooperate and consult with the Kentucky Board of Pharmacy.

Effective: January 1, 2025

History: Created 2024 Ky. Acts ch. 104, sec. 3, effective January 1, 2025; and amended 2024 Ky. Acts ch. 213, sec. 1, effective January 1, 2025.

Legislative Research Commission Note (1/1/2025). This statute was created by 2024 Ky. Acts ch. 104, sec. 3, and subsequently amended by 2024 Ky. Acts ch. 213, sec. 1, and has been codified as amended.

Legislative Research Commission Note (1/1/2025). 2024 Ky. Acts chs. 104 and 213 provide that this statute shall apply to contracts issued, delivered, entered, renewed, extended, or amended on or after January 1, 2025.

Legislative Research Commission Note (7/15/2024). 2024 Ky. Acts ch. 104, sec. 21, reads as follows:

"(1) Except as provided in subsection (2) of this section, on or before January 1, 2025, the commissioner of the Department of Insurance shall promulgate any emergency and ordinary administrative regulations necessary to implement the provisions of this Act, including but not limited to the administrative regulation required under subsection (2)(c)2.c.i. of Section 3 of this Act [this statute].

(2) On or before June 1, 2026, the commissioner of insurance shall promulgate any emergency and ordinary administrative regulations required under subsection (2)(c)2.a. of Section 3 of this Act [this statute]."