AN ACT relating to pharmacy benefit managers.

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

➔SECTION 1. A NEW SECTION OF SUBTITLE 12 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(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. 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) "Health plan":

1. Means any policy, certificate, contract, or plan that offers or provides coverage in this state for pharmacy or pharmacist services, whether such coverage is by direct payment, reimbursement, or otherwise;

2. Shall include but not be limited to a health benefit plan defined in KRS 304.17A-005; and

3. Shall not include a policy, certificate, contract, or plan that offers or provides Medicaid services under KRS Chapter 205;

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

1. With which the pharmacy benefit manager shares common ownership, management, or control;

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

3. Which shares any common members on its board of directors with the pharmacy benefit manager; or

4. Which shares managers in common with the pharmacy benefit manager;

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

(e) "Pharmacy or pharmacist services" means any health care procedures, treatments within the scope of practice of a pharmacist, or services provided by a pharmacy or pharmacist, including the provision of:

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

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

(f) "Rebate":

1. Means a discount, price concession, or payment that is:

a. Based on utilization of a prescription drug; and

b. Paid by a manufacturer or third party, directly or indirectly, to a pharmacy benefit manager, pharmacy services administration organization, or a pharmacy after a claim has been processed and paid at a pharmacy; and

2. Shall include, without limitation, incentives, disbursements, and reasonable estimates of a volume-based discount; and

(g) "Spread pricing" means any technique by which a pharmacy benefit manager charges or claims an amount from an insurer or third-party payor for pharmacy or pharmacist services, including payment for a prescription drug, that is different than the amount the pharmacy benefit manager pays

to the pharmacy or pharmacist that provided the services.

(2) The provisions of this section shall be subject to all applicable federal law and regulations. To the extent any provision of this section conflicts with an applicable federal law or regulation, the applicable federal law or regulation shall control.

(3) Every contract between a pharmacy or pharmacist and a pharmacy benefit manager for the provision of pharmacy or pharmacist services under a health plan, either directly or through a pharmacy services administration organization, shall prohibit all of the following:

(a) Requiring pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to Kentucky Board of Pharmacy standards or requirements;

(b) Discrimination against any pharmacy;

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

1. The original claim was submitted fraudulently; or

2. The pharmacy or pharmacist received an actual overpayment;

(d) Reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement, including permitting an insurer or any other third-party payor to make such a reduction. This prohibition shall include, without limitation, creating, imposing, or establishing:

1. Direct or indirect remuneration fees;

2. Any effective rate, including but not limited to:

a. Generic effective rates;

b. Dispensing effective rates; and

c. Brand effective rates;

3. In-network fees;

4. Performance fees;

5. Pre-adjudication fees;

6. Post-adjudication fees; and

7. Any other mechanism that reduces, or aggregately reduces, payment for pharmacy or pharmacist services;

(e) Paying or reimbursing a pharmacy or pharmacist for the ingredient drug product component of pharmacy or pharmacist services less than the national average drug acquisition cost or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost; and

(f) Creating, modifying, implementing, or establishing, directly or indirectly, any fee on a pharmacy or pharmacist without first seeking and obtaining written approval from the commissioner to do so.

(4) The discrimination prohibited under subsection (3)(b) of this section shall include but not be limited to:

(a) When creating or establishing a pharmacy network, discriminating against any pharmacy or pharmacist that is:

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

2. Willing to agree to or accept reasonable terms and conditions established by the pharmacy benefit manager for network participation, including obtaining preferred participation status;

(b) Requiring, or incentivizing, an insured to receive pharmacy or pharmacist

services from a pharmacy affiliate;

(c) Reimbursing the pharmacy or pharmacist for a prescription drug or other service in an amount, which shall be calculated on a per-unit basis using the same generic product identifier or generic code number, less than the amount the pharmacy benefit manager reimburses a pharmacy affiliate for providing the same prescription drug or other service; and

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

(5) A pharmacy benefit manager providing pharmacy benefit management services under a health plan shall not do any of the following:

(a) Create, modify, implement, or establish, directly or indirectly, any fee on an insured without first seeking and obtaining written approval from the commissioner to do so; or

(b) Require an insured to use a mail-order pharmaceutical distributor or mail-order pharmacy.

(6) Every contract between an insurer or other third-party payor and a pharmacy benefit manager for the provision of pharmacy benefit management services under a health plan shall:

(a) Provide that the pharmacy benefit manager shall:

1. Owe a fiduciary duty to the insurer or other third-party payor; and

2. Not utilize any form of spread pricing; and

(b) Entitle the insurer or third-party payor to full disclosure from the pharmacy benefit manager of the terms of a contract between the pharmacy benefit manager and any other person or entity concerning the performance of the pharmacy benefit management services, including but not limited to:

1. The purchase price for prescription drugs; and

2. The amount of any rebate provided in connection with the purchase of prescription drugs.

(7) (a) A pharmacy benefit manager shall allow, at least once each calendar year, for any party that has contracted with the pharmacy benefit manager to provide services under a health plan to request an audit of compliance with the contract.

(b) The audit may include full disclosure of rebates, whether product specific or general rebates, and any other revenue and fees derived by the pharmacy benefit manager from the contract.

(c) A contract shall not contain provisions that impose unreasonable fees or conditions that would severely restrict a party's right to conduct an audit under this subsection.

(d) The commissioner may establish a procedure to release information from an audit or examination performed by the commissioner to a party that has requested an audit under this subsection in a manner that does not violate confidential or proprietary information laws.

(8) A pharmacy benefit manager shall:

(a) Disclose, upon request from a party that has contracted with the pharmacy benefit manager to provide services under a health plan, to the party the actual amounts paid by the pharmacy benefit manager to any pharmacy; and

(b) Provide notice to a party contracting with the pharmacy benefit manager to provide services under a health plan of any consideration that the pharmacy benefit manager receives from a pharmacy manufacturer for any name brand dispensing of a prescription when a generic or biologically similar product is available for the prescription.

(9) (a) Pharmacy benefit managers providing pharmacy benefit management

services under a health plan shall submit an annual report to the commissioner.

(b) The annual report shall:

1. Be submitted in a manner and format prescribed by the commissioner through administrative regulation; and

2. Include but not be limited to:

a. A list of the health plans that are administered by the pharmacy benefit manager; and

b. For health plan contracts entered during the immediately preceding calendar year:

i. The aggregate amount of rebates, and administrative fees from pharmaceutical manufacturers, that the pharmacy benefit manager received for all insurers and third-party payors and each insurer and third-party payor;

ii. The aggregate amount of rebates retained by the pharmacy benefit manager for all insurers and third-party payors; and

iii. The highest, lowest, and mean aggregate rebate retained for all insurers and third-party payors and each insurer and third-party payor.

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

(10) (a) Pharmacy benefit managers shall not transfer, share, or receive Kentucky pharmacy records containing patient identifiable data to, with, or from a

pharmacy affiliate for any commercial purpose.

(b) Nothing in this subsection shall be construed to prohibit:

1. The exchange of information between a pharmacy benefit manager and its pharmacy affiliate for purposes that are otherwise permitted by law, including but not limited to reimbursement for pharmacy or pharmacist services, auditing of pharmacy records, public health activities, and utilization review; or

2. A pharmacy benefit manager from entering into an agreement with a pharmacy affiliate to provide pharmacy or pharmacist services to insureds if the agreement is in compliance with this chapter.

(11) In order to effectuate, or aid the effectuation of, any provision of this chapter relating to pharmacy benefit managers, the commissioner may promulgate administrative regulations that establish:

(a) Prohibited practices, including market conduct practices, of pharmacy benefit managers that provide pharmacy benefit management services under a health plan;

(b) Data reporting in connection with violations of this chapter; and

(c) Specifications for the sharing of information with pharmacy affiliates.

(12) This section shall apply to all contracts issued, delivered, entered, renewed, extended, or amended on or after the effective date of this section.

➔Section 2. KRS 304.17A-708 is amended to read as follows:

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

(2) An insurer shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twenty-four (24)

months after the date that the provider received payment for the claim from the insurer.

(3) (a) Except in cases of fraud, an insurer may only retroactively deny reimbursement to a provider during the twenty-four (24) month period after the date that the insurer paid the claim submitted by the provider.

(b) An insurer that retroactively denies reimbursement to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial.

(c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) If an insurer retroactively denies reimbursement for services as a result of coordination of benefits with another insurer, the provider shall have twelve (12) months from the date that the provider received notice of the denial, unless the insurer that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the insurer, the medical assistance program, or the Medicare program responsible for payment.

(e) Notwithstanding the provisions of this subsection, a pharmacy benefit manager shall not retroactively deny reimbursement in violation of Section 1 of this Act.

➔Section 3. KRS 304.17A-712 is amended to read as follows:

(1) Except as provided in subsection (2) of this section, if an insurer determines that payment was made for services rendered to an individual who was not eligible for coverage or that payment was made for services not covered by a covered person's health benefit plan, the insurer shall give written notice to the provider and:

(a) ~~[(1)]~~ Request a refund from the provider; or

(b) ~~[(2)]~~ Make a recoupment of the overpayment from the provider in accordance with KRS 304.17A-714.

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

➔Section 4. KRS 304.17A-714 is amended to read as follows:

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

(a) Request a refund from the provider; or

(b) Indicate on the notice that, within thirty (30) calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with subsection (2) of this section, the amount of the overpayment will be recouped from future payments.

(2) If a provider disagrees with the amount of the overpayment, the provider shall within thirty (30) calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer.

(3) If a provider files a dispute in accordance with subsection (2) of this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in

subsection (2) of this section, the insurer may recoup the amount due from future payments.

(4) All disputes submitted by providers pursuant to subsection (2) of this section shall be processed in accordance and completed within thirty (30) days with the insurer's provider appeals process.

(5) An insurer may recover an overpayment resulting from an error in the payment rate or method by requesting a refund from the provider or making a recoupment of the overpayment from the provider, subject to the provisions of subsection (6) of this section. A provider may dispute such recoupment in accordance with the provisions contained in KRS 304.17A-708.

(6) If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within twenty-four (24) months from the date that the insurer paid the claim, and at the actual time of recoupment give the provider written or electronic documentation that specifies:

(a) The amount of the recoupment;

(b) The covered person's name to whom the recoupment applies;

(c) Patient identification number; and

(d) Date of service.

(7) Notwithstanding the provisions of this section, a pharmacy benefit manager shall not collect any amounts in violation of Section 1 of this Act.

➔Section 5. If any provision of this Act, or this Act's application to any person or circumstance, is held invalid, the invalidity shall not affect other provisions or applications of the Act, which shall be given effect without the invalid provision or application, and to this end the provisions and applications of this Act are severable.

➔Section 6. The commissioner of insurance shall promulgate administrative regulations to implement the provisions of this Act on or before January 1, 2022.

➔Section 7. Sections 1 to 5 of this Act take effect on January 1, 2022.