SENATE

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

2022 REGULAR SESSION

Amend printed copy of **HB 240/GA**

Unofficial Document

On page 3, after line 14, by inserting the following:

"➔Section 2. KRS 304.17A-164 is amended to read as follows:

(1) As used in this section:

(a) "Cost sharing"***:***

1. 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[, which may be subject to annual limitations on cost sharing, including those imposed under 42 U.S.C. secs. 18022(c) and 300gg-6(b),] in order for ***the insured***[an individual] to receive a specific health care service covered by the plan***; and***

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

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

(c) "Health plan":

1. Means ***any***[a] policy, ***certificate,*** contract, [certificate,]or ***plan that offers or***

Amendment No. SFA | Rep. Sen. Ralph Alvarado

Committee Amendment | Signed:

Floor Amendment | LRC Drafter:

Adopted: | Date:

Rejected: | Doc. ID: XXXX

Not for Filing

Unofficial Document

provides coverage in this state for pharmacy or pharmacist services, whether such coverage is by direct payment, reimbursement, or otherwise;

2. Includes a health benefit plan; and

3. Does not include a policy, certificate, contract, or plan that offers or provides Medicaid services under KRS Chapter 205[~~agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the cost of health care services; and~~

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

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

(e) "Insurer"***:***

1. Means any of the following persons or entities that offer or issue a health plan:

a. An insurance company;

b. A health maintenance organization;

c. A limited health service organization;

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

e. A provider-sponsored integrated health delivery network;

f. A self-insured employer-organized association;

g. A nonprofit hospital, medical-surgical, dental, and health service corporation; or

Unofficial Document

h. Any other third-party payor that is:

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

ii. Not exempt by federal law from regulation under the insurance laws of this state;

2. Includes any person or entity that has contracted with a state or federal agency to provide coverage in this state for pharmacy or pharmacist services, except persons or entities that have contracted to provide Medicaid services under KRS Chapter 205; and

3. Includes[~~:~~

~~1. An insurer offering a health plan providing coverage for pharmacy benefits; or~~

~~2.~~]Any [~~other~~]administrator of pharmacy benefits under a health plan;

(f) "Person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, government, or governmental subdivision or agency;

(g) "Pharmacy" includes:

1. A pharmacy, as defined in KRS Chapter 315;

2. A pharmacist, as defined in KRS Chapter 315; ***and***[~~or~~]

3. Any employee of a pharmacy or pharmacist;[~~ and~~]

(h) "Pharmacy benefit manager" has the same meaning as in ***KRS 304.9-020, except for purposes of this section, the term does not include a pharmacy benefit manager that is contracted by and acting under the direction of any hospital or health system that provides a self-insured plan if the hospital or health system owns a pharmacy; and***

(i) "Pharmacy or pharmacist services":

Unofficial Document

1. Means any health care procedures, treatments within the scope of practice of a pharmacist, or services provided by a pharmacy or a pharmacist; and

2. Includes the provision of:

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

b. Home medical equipment, as defined in KRS 309.402[KRS 304.17A-161].

(2) To the extent permitted under federal law, an insurer [issuing or renewing a health plan on or after January 1, 2022,]or a pharmacy benefit manager[,] shall not:

(a) Require an insured [purchasing a prescription drug]to***:***

1. Pay a cost-sharing amount ***for pharmacy or pharmacist services*** greater than the amount the insured would pay for the ***services***[drug] if he or she were to purchase the ***services***[drug] without coverage;***or***

2. a. Use a mail-order pharmaceutical distributor, including a mail-order pharmacy, in order to receive coverage under the plan.

b. Conduct prohibited under this subparagraph includes but is not limited to requiring the use of a mail-order pharmaceutical distributor, including a mail-order pharmacy, to furnish a health care provider a prescription drug by the United States Postal Service or a common carrier for subsequent administration in a hospital, clinic, pharmacy, or infusion center;

(b) ***Impose upon an insured any cost-sharing requirement, fee, or other condition relating to:***

1. Pharmacy or pharmacist services received from a retail pharmacy or pharmacist that is greater, or more restrictive, than what would otherwise be imposed if:

Unofficial Document

a. The insured used a mail-order pharmaceutical distributor, including a mail-order pharmacy; and

b. The retail pharmacy or pharmacist has agreed to accept reimbursement at no more than the amount that would have been reimbursed to the mail-order pharmaceutical distributer;

2. Prescription drugs furnished by a health care provider for administration in a hospital, clinic, pharmacy, or infusion center that is greater, or more restrictive, than what would otherwise be imposed if a mail-order pharmaceutical distributor, including a mail-order pharmacy, furnished the prescription drugs to the health care provider; or

3. Pharmacy or pharmacist services that is not equally imposed upon all insureds in the same benefit category, class, or cost-sharing level under the health plan, unless otherwise required or permitted under this section;

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

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

2. To any fully insured health benefit plan or self-insured plan provided to an employee;

(d)[~~(c)~~]Prohibit a pharmacy from discussing any information under subsection (3) of this section; or

Unofficial Document

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

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

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

➔SECTION 3. A NEW SECTION OF SUBTITLE 17A OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

To the extent permitted under federal law:

(1) As used in this section:

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

(b) "National drug code number" means the unique national drug code number that identifies a specific approved drug, its manufacturer, and its package presentation.

(2) A pharmacy benefit manager providing pharmacy benefit management services on behalf of a health plan shall not discriminate against any pharmacy, including a pharmacy owned by or contracted with a covered entity.

(3) Conduct prohibited by subsection (2) of this section includes but is not limited to:

(a) Reimbursing a covered entity, including any pharmacy owned by or contracted with the covered entity, for a pharmacy-dispensed drug at an amount that is lower than the amount paid for the same drug by national drug code number to an entity that is not a covered entity or a pharmacy that is not owned by or contracted with a covered entity; and

(b) Assessing any pharmacy-related fee, chargeback, or other adjustment, including any fee, chargeback, or adjustment relating to pharmacy dispensed drugs, upon a

Unofficial Document

covered entity, including any pharmacy owned by or contracted with a covered entity, that is not equally assessed on an entity that is not a covered entity or a pharmacy that is not owned by or contracted with a covered entity.".