AN ACT relating to step therapy protocols.

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

➔Section 1. KRS 304.17A-163 is amended to read as follows:

(1) As used in this section and KRS 304.17A-1631, unless the context requires otherwise:

(a) "Clinical practice guidelines" means a systematically developed statement to assist decision making by health care providers and patients about appropriate healthcare for specific clinical circumstances and conditions;

(b) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and clinical practice guidelines used by the insurer, health plan, pharmacy benefit manager, or private review agent to determine the medical necessity and appropriateness of health care services;

(c) "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 pursuant to a step therapy protocol, regardless of whether***:***

a. The ***step therapy*** protocol is described as a step therapy protocol; ***or***

b. The coverage is provided:

i. By direct payment, reimbursement, or otherwise; or

ii. On a fully insured or self-insured basis or any combination thereof; and

2. Shall include but not be limited to a health benefit plan;

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

(e) "Private review agent" has the same meaning as in KRS 304.17A-600;

(f) "Step therapy exception" means a determination that a step therapy protocol

should be overridden in favor of immediate coverage of the health care provider's selected prescription drug; and

(g) "Step therapy protocol" means a protocol, policy, or program that establishes the specific sequence in which prescription drugs that are for a specified medical condition and medically appropriate for a particular insured are covered by an insurer or health plan.

(2) (a) Except as provided in paragraph (b) of this subsection, clinical review criteria developed by an insurer, health plan, pharmacy benefit manager, or private review agent to establish a step therapy protocol shall be based on clinical practice guidelines that:

1. Recommend that prescription drugs be taken in the specific sequence required by the step therapy protocol;

2. Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

a. Requiring members to:

i. Disclose any potential conflict of interests with entities, including insurers, health plans, and pharmaceutical manufacturers; and

ii. Recuse himself or herself from voting if the member has a conflict of interest;

b. Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus; and

c. Offering opportunities for public review and comments;

3. Are based on high quality studies, research, and medical practice;

4. Are created by an explicit and transparent process that:

a. Minimizes biases and conflicts of interest;

b. Explains the relationship between treatment options and outcomes;

c. Rates the quality of the evidence supporting recommendations; and

d. Considers relevant patient subgroups and preferences; and

5. Are continually updated through a review of new evidence, research, and newly developed treatments.

(b) In the absence of clinical practice guidelines that meet the requirements of paragraph (a) of this subsection, an insurer, health plan, pharmacy benefit manager, or private review agent may use peer-reviewed publications to establish step therapy protocols.

(c) When establishing clinical review criteria for a step therapy protocol, an insurer, health plan, pharmacy benefit manager, or private review agent shall take into account the needs of atypical patient populations and diagnoses.

(d) 1. An insurer, health plan, pharmacy benefit manager, or private review agent shall, upon written request, provide all specific written clinical review criteria relating to a particular condition or disease, including clinical review criteria relating to a step therapy exception determination.

2. The clinical review criteria and other clinical information shall be made available:

a. On the insurer's, health plan's, pharmacy benefit manager's, or private review agent's website; and

b. To a health care professional on behalf of an insured upon written request.

(e) Nothing in this subsection shall be construed to require an insurer, health plan, pharmacy benefit manager, or private review agent to establish a new entity to

develop clinical review criteria used for step therapy protocols.

(3) (a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, private review agent, or a pharmacy benefit manager by a step therapy protocol, the insured and prescribing provider shall have access to a clear, readily accessible, and convenient process to request a step therapy exception.

(b) ***To satisfy the requirements of paragraph (a) of this subsection and subject to paragraph (d) of this subsection,*** an insurer, health plan, private review agent, or pharmacy benefit manager ***shall***:

1. ~~[May use its existing medical exceptions process to satisfy the requirements of paragraph (a) of this subsection;~~

~~2. Shall]~~Make the step therapy protocol***, including:***

a. All rules and criteria related to the step therapy protocol; and

b. The specific information and documentation that must be submitted by a prescribing provider or insured to be considered a complete request for a step therapy exception;

easily accessible on its website; and

2.~~[3.]~~ ***On or before January 1, 2027, ensure that the electronic process for requesting and transmitting prior authorization for a drug required under KRS 304.17A-167 includes the ability for prescribing providers to electronically transmit a complete request for a step therapy exception to the insurer, health plan, private review agent, or pharmacy benefit manager.***

(c) The process required under paragraph (b)2. of this subsection shall:

1. Be integrated;

2. Include an electronic list of the grounds for granting a step therapy exception request, which shall include the grounds set forth in

subsection (4)(a)2. of this section; and

3. Allow a prescribing provider to submit:

a. The grounds for a step therapy exception request by electronically selecting one (1) or more options from the list required under subparagraph 2. of this paragraph;

b. All necessary information required under subsection (4)(a)1. of this section; and

c. All additional or clinically relevant information required under subsection (4)(b)2. of this section ~~[Shall, upon request, disclose all rules and criteria related to the step therapy protocol to all prescribing providers, including the specific information and documentation that must be submitted by a prescribing provider or insured to be considered a complete request for a step therapy exception]~~.

(d) Paragraph (b)2. of this subsection shall apply to Medicaid and KCHIP benefits as provided in KRS 205.522 and 205.6485 to the extent authorized by federal law.

(4) (a) A step therapy exception request, or an internal appeal under KRS 304.17A-617 of a step therapy exception request denial, shall be granted by the insurer, health plan, private review agent, or the pharmacy benefit manager within forty-eight (48) hours if:

1. All necessary information to perform the step therapy exception review, or make the appeal determination, has been provided; and

2. One (1) of the following apply:

a. The required prescription drug is:

i. Contraindicated or will likely cause an adverse reaction by physical or mental harm to the insured; or

ii. Expected to be ineffective based on the known clinical characteristics of the insured and the prescription drug regimen;

b. Based on clinical appropriateness, the required prescription drug is not in the best interest of the insured because the insured's use of the required prescription drug is expected to:

i. Cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;

ii. Worsen a comorbid condition of the insured; or

iii. Decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities;

c. The insured has tried the required prescription drug while under the insured's current or a previous health plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event; or

d. The insured is stable on the prescription drug selected by the insured's health care provider for the medical condition under consideration while under a current or previous health plan.

(b) If a request for a step therapy exception, or an internal appeal under KRS 304.17A-617 of a step therapy exception request denial, is incomplete or additional clinically relevant information is required, the insurer, health plan, pharmacy benefit manager, or private review agent shall notify the prescribing provider within forty-eight (48) hours of submission of the request or appeal:

1. That the request or appeal is incomplete; and

2. What additional or clinically relevant information is required in order to

approve or deny the step therapy exception.

(5) If a step therapy exception request determination, notification under subsection (4)(b) of this section, or internal appeal determination under KRS 304.17A-617 of a step therapy exception request denial by an insurer, health plan, pharmacy benefit manager, or private review agent is not received by the prescribing provider within the time period specified in subsection (4) of this section, the step therapy exception request or internal appeal shall be deemed granted.

(6) An insured or a provider may:

(a) Initiate an internal appeal under KRS 304.17A-617 upon the denial of a step therapy exception request under this section; and

(b) Request an external review under KRS 304.17A-623 upon the denial of an internal appeal under paragraph (a) of this subsection.

(7) ***(a) Subject to paragraph (b) of this subsection,*** an insurer, health plan, pharmacy benefit manager, or private review agent~~[shall]~~:

1.~~[(a)]~~ ~~[Upon the granting of a step therapy exception request, internal appeal, or external review, authorize]~~***Shall begin*** coverage for the prescription drug selected by the insured's health care provider ***on the date the provider submits a step therapy exception request***;~~[or]~~

2.~~[(b)]~~ ***May terminate coverage for the prescription drug selected by the insured's health care provider:***

a. Upon the denial of a step therapy exception request***; or***

b. Forty-eight (48) hours after the notification required under subsection (4)(b) of this section is provided to the insured's health care provider if the provider has not submitted the additional or clinically relevant information required in the notification; and

3. Upon the denial of a step therapy exception request or internal appeal,

shall:

a. Inform the insured of the internal appeal or external review process, as applicable***; and***

b. Not retroactively deny, reduce payment for, or seek any refunds or recoupments for coverage previously provided under this subsection for a prescription drug.

(b) Paragraph (a) of this subsection shall apply to Medicaid and KCHIP benefits as provided in KRS 205.522 and 205.6485 to the extent authorized by federal law.

(8) (a) Except as provided in paragraph (b) of this subsection, the duration of any step therapy protocol shall not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing provider.

(b) When the prescribing provider can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy protocol may be extended up to seven (7) additional days.

(9) Nothing in this section shall be construed to prevent:

(a) An insurer, health plan, pharmacy benefit manager, or private review agent from requiring an insured to try:

1. An AB-rated generic equivalent prior to providing coverage for the reference listed drug;
2. An interchangeable biological product, as defined in 42 U.S.C. sec. 262(i)(3), prior to providing coverage for the reference product; or
3. A biosimilar biological product, as defined in 42 U.S.C. sec. 262(i)(2), prior to providing coverage for the reference product;

unless the requirement meets any of the criteria set forth in subsection (4)(a)2.

of this section pursuant to a step therapy exception request submitted under subsection (4) of this section;

(b) An insurer, health plan, pharmacy benefit manager, or private review agent from requiring a pharmacist to effect substitutions of prescription drugs consistent with KRS 217.814 to 217.896 and 304.17A-535; or

(c) A health care provider from prescribing a prescription drug that is determined to be medically appropriate.

➔Section 2. If the Cabinet for Health and Family Services or the Department for Medicaid Services determines that a state plan amendment, waiver, or any other form of authorization or approval from any federal agency to implement Section 1 of this Act is necessary to prevent the loss of federal funds or to comply with federal law, the cabinet or department:

(1) Shall, within 90 days after the effective date of this section, request the necessary federal authorization or approval to implement Section 1 of this Act; and

(2) May only delay implementation of the provisions of Section 1 of this Act for which federal authorization or approval was deemed necessary until the federal authorization or approval is granted.

➔Section 3. Sections 1 and 2 of this Act, and KRS 205.522 and 205.6485 shall constitute the specific authorization required under KRS 205.5372(1).

➔Section 4. This Act applies to policies, certificates, contracts, and plans issued or renewed on or after the effective date of this Act.