

**Kentucky Department of Insurance
Initial Cost Defrayal
Statement**

After reviewing BR 1870/ HB 453 as currently drafted, the Department's initial determination is that this bill does not contain a mandated health benefit that would result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended.

Therefore, a cost defrayal analysis will not be performed.

Sharon P. Clark

2/06/2026

(Signature of Commissioner/Date)

Fiscal Impact Report – BR1870/HB453

Pharmacy Cost Sharing

PREPARED FOR THE KENTUCKY DEPARTMENT OF INSURANCE

FEBRUARY 6, 2026

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Introduction

Lewis & Ellis, LLC (L&E) was engaged by the Kentucky Department of Insurance (KY DOI) to perform a fiscal impact analysis of BR1870/HB453, which would:

1. Prohibit insurers and pharmacy benefit managers (PBMs) from requiring an insured to pay prescription drug cost-sharing greater than the drug's cash price, including prices available through discount cards or other direct-to-consumer programs.
2. Require any amount paid by or on behalf of an insured (including cash payments up to the negotiated price) to be credited toward an insured's cost-sharing requirement, such as deductibles or out-of-pocket maximums.

Kentucky Revised Statute (KRS) 6.948^a mandates that the sponsor of any bill proposing a health benefit mandate must request a financial impact statement from the Kentucky Department of Insurance (DOI). This statement must be completed within 30 days of the request and should include the following:

1. An assessment of the impact of the mandated health benefit on administrative expenses, premiums, and the overall cost of healthcare including any potential future cost savings.
2. Supporting documentation, including studies, written opinions, calculations, and citations that validate the findings and conclusions.
3. An estimate of any potential cost savings in the future, along with an explanation of why the bill would or would not lead to such savings, and
4. A certification confirming the accuracy of the information provided.

Additionally, KRS 6.948 mandates that the sponsor of any bill proposing a health benefit mandate must also request a federal cost defrayal impact statement from the Kentucky DOI. This statement must be completed within 30 days of the request. The federal defrayal cost impact statement shall:

1. Indicate whether a bill or amendment that contains a mandated health benefit may result in the state being required to make payments to defray costs.
2. If applicable, indicate which provision(s) of the bill or amendment may trigger the requirement to make payments to defray the costs.
3. If applicable, include an estimate of the payment amount that the state may be required to make if the bill or amendment is enacted into law.

L&E is tasked with performing the health mandate fiscal impact and federal cost defrayal impact analyses for the Kentucky insurance market, excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs. The fiscal impact analyses for these programs are performed by other entities. For this analysis, L&E reviewed literature, gathered statistics from public sources^b, and used data from the KY DOI's 2024 Insurer Annual Data report.

^a As amended by 2024 House Bill 635.

^bIncluding reports for other states who have considered or passed similar legislation.

Administrative Expense Impact Analysis

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on administrative expenses**, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. It is our assumption that insurers either already provide coverage for the mandated benefits or the additional administrative requirements imposed by this mandate would not significantly impact the administrative costs relative to current levels.

Premium Impact Analysis

To estimate BR1870/HB453’s premium impact, L&E evaluated data from KY DOI’s 2024 Insurer Annual Data report and publicly available sources. L&E used the collected information and data to estimate low-end and high-end assumptions for each variable that could impact cost or utilization. The ranges for each variable were then used to estimate the aggregate premium impact range.

While L&E selected specific assumptions to develop a range for the estimated premium impact, it is not intended to represent only the low- and high- scenarios illustrated. Each assumption range is intended to capture the various uncertainties inherent in each assumption and to provide an estimated range of resulting potential outcomes. Therefore, the final estimated aggregate premium impact range implicitly captures a wide range of scenarios and assumptions.

Each of the following sections discuss the data used to inform each assumption evaluated by L&E.

CREDIT TOWARDS COST-SHARING REQUIREMENTS

Based on research¹, L&E estimates an immaterial impact to claim cost for the proposed that any amount paid by or on behalf of an insured be credited to an insured’s cost-sharing requirement. This determination considers that cash-pay behavior among insured patients is most common for lower-cost generic and maintenance medications, where out-of-pocket cash prices are often lower than insurance copays. By contrast, for higher-cost brand or specialty drugs, insured patients rarely choose cash pay because the absolute cash price remains unaffordable and insurance significantly reduces out-of-pocket burden. While the crediting requirement may accelerate the timing at which some insureds reach deductibles or out-of-pocket maximums, the affected population is limited and the associated claim cost impact is expected to be small. Therefore, the remainder of the fiscal impact assumptions and calculation focus on the prohibition of cost-sharing greater than a drug’s cash price.

AVERAGE NUMBER OF RX CLAIMS PER INSURED PER YEAR

Available data² indicates that, on average, insureds have approximately 12 prescriptions (30-day supply) per year. Based on this data, L&E designated the following range for use in the fiscal impact calculation.

Average Number of Rx Claims per Insured	
Low	High
11	13

PERCENTAGE OF PHARMACY CLAIMS WITH COST-SHARING GREATER THAN CASH PRICE

Drawing from available information, L&E estimated the percentage of pharmacy claims that have cost-sharing greater than cash price. Based on the data reviewed³, L&E selected the following range:

% of Rx Claims w/ Cost-Sharing > Cash Price	
Low	High
20%	25%

AVERAGE COST DIFFERENCE

For medications where cost sharing exceeds the cash price, the average difference between the cost-sharing amount and the cash price is assumed to fall within the following range, based on the reviewed research³.

Cost-Sharing & Cash Price Average Differential per Script	
Low	High
\$3.00	\$8.00

RESULTING PREMIUM IMPACT ESTIMATE

The following table illustrates the range of assumptions selected by L&E and the resulting estimated premium impact range.

Claim Cost Impact Calculation		
Assumption	Low	High
Projected 2026 KY Insured Members^e (a)	343,644	343,644
Average Number of Rx Claims per Insured per Year (b)	11	13
Projected 2026 KY Pharmacy Claims^c (c)=(a)*(b)	3,780,079	4,467,367
% of Rx Claims w/ Cost-Sharing > Cash Price (d)	20%	25%
Cost-Sharing & Cash Price Average Differential per Script (e)	\$3.00	\$8.00
Total Cost Impact^d (f)=(c)*(d)*(e)	\$2,268,048	\$8,934,733
Projected 2026 KY Insured Members^e (g)=(a)	343,644	343,644
Mandate Claim Cost Impact PMPM (h)=(f)/(g)/12	\$0.55	\$2.17
Projected 2026 Total Claims Costs PMPM (i)	\$626.28	\$626.28
Mandate Claim Cost % Impact (j)=(h)/(i)	0.1%	0.3%

^c Based on 2024 Insurer Annual Data report provided by the KY DOI. Excludes KEHP and Medicaid.

^d i.e., cost assumed to be shifted from the member to the PBM/Insurer.

^e Excluding the Kentucky Employee Health Plan (KEHP) and the Kentucky Medicaid programs.

Premium Impact Calculation		
Assumption	Low	High
Projected 2026 KY Average Loss Ratio ^c (k)	91.1%	91.1%
Projected 2026 KY Average Premium PMPM (l)=(i)/(k)	\$687.81	\$687.81
Mandate Premium Impact PMPM (m)=(h)/(k)	\$0.60	\$2.38
Mandate Premium % Impact (n)=(m)/(l)	0.1%	0.3%
Projected 2026 KY Insured Members ^e (o)=(a)	343,644	343,644
Mandate Premium Total Annual Impact (p) = (m)*(o)*12	\$2.5M	\$9.8M

Total Cost of Health Care Impact Analysis

L&E defines ‘Total Cost of Health Care’ as being equal to the sum of the Allowed Cost (i.e., the amount paid by the insurer plus the amount paid by the insured) and the insurer Non-Benefit Expenses. Additionally, as required by KRS 6.948, L&E considered the impact of potential future cost savings.

POTENTIAL FOR FUTURE COST SAVINGS

L&E acknowledges the potential for long-term cost savings arising from improved medication adherence resulting from the out-of-pocket financial relief provided to insured individuals under BR1870/HB453. However, while some research examines cost savings when cost sharing is eliminated for certain drugs⁴, the available literature does not quantify the magnitude of potential cost savings associated with incremental levels of financial relief. Based on experience and actuarial judgment, L&E estimates the impact of potential future savings as a result of the BR1870/HB453 to be immaterial (within +/- 0.05%).

RESULTING TOTAL COST OF HEALTH CARE IMPACT ESTIMATE

The proposed bill is estimated to have **an immaterial (within +/- 0.05%) impact on total cost of health care**, including potential future cost savings, based upon our analysis of the proposed mandate and our experience with similar health insurance benefits. This estimate differs from the premium impact estimate because the impact of the mandate shifts costs from the insured to the insurer, creating an impact on premiums but not an impact on allowed cost.

Cost Defrayal Impact Analysis

Based on L&E’s research and actuarial judgment, L&E determined that this bill does not contain a mandated health benefit that would result in the state being required to make payments to defray costs under 42 U.S.C sec 18031(d)(3) and 45 C.F.R. sec 155.170, as amended. This is based on the understanding that cost sharing mandates do not trigger defrayal.

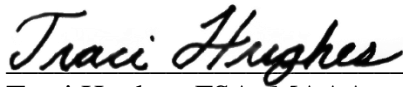
L&E has disclosed its defrayal determination based on its earnest interpretation of federal guidance available as of the date of this report. However, determination of defrayal is ultimately under the regulatory purview of Centers for Medicare and Medicaid Services (CMS).

Certification of Accuracy

L&E believes the estimates are accurate based on the information disclosed in the report. To the extent that there are material inaccuracies, misrepresentations, or lack of adequate disclosure in the data, the results may be accordingly affected. Several of the assumptions made in this analysis are subject to uncertainty and it is expected that actual results could differ from the calculated estimates.



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2/06/2026

(Signature of Commissioner/Date)

ASOP 41 Disclosures

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations^f, promulgates actuarial standards of practice (ASOPs) for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct^g, to observe the ASOPs of the ASB when practicing in the United States. ASOP 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

Identification of the Responsible Actuary

The responsible actuaries are:

- Bobby Dorman, ASA, MAAA, Vice President & Consulting Actuary
- Traci Hughes, FSA, MAAA, Vice President & Principal

These actuaries are available to provide supplementary information and explanation.

Identification of Actuarial Documents

The date of this document is February 6, 2026. The date (a.k.a. “latest information date”) through which data or other information has been considered in performing this analysis is February 6, 2026.

Disclosures in Actuarial Reports

- The contents of this report are intended for the use of the Kentucky Department of Insurance. The authors of this report are aware that it may be distributed to third parties. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis, LLC is financially and organizationally independent from the health insurers and providers involved in this analysis. There is nothing that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the Kentucky Department of Insurance in assessing the financial impact and federal cost defrayal impact of proposed legislation that includes a proposed health benefit mandate.
- The responsible actuaries identified above are qualified as specified in the Qualification Standards of the American Academy of Actuaries.
- L&E has reviewed the data provided by the insurers and Kentucky Department of Insurance for reasonableness, but the data has not been audited. L&E nor the responsible actuaries assume responsibility for these items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.

^f The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.

^g These organizations adopted identical *Codes of Professional Conduct* effective January 1, 2001.

- Several of the assumptions made in this analysis are subject to uncertainty and it is not unexpected that actual results could differ from the calculated estimates.
- L&E is not aware of any subsequent events that may have a material effect on the findings.
- There are no other documents or files that accompany this report.

Actuarial Findings

The actuarial findings of the report can be found in the body of this report.

Bibliography

¹ Pharmaceutical Research and Manufacturers of America. (2025, May). Comments on co-pay accumulators (Center for Insurance Policy and Research Call Materials). National Association of Insurance Commissioners. Retrieved January 25, 2026, https://content.naic.org/sites/default/files/call_materials/PhRMA%20Comments%20on%20Co-Pay%20Accumulators.pdf

² California Department of Managed Health Care. (2025). *SB 17 Prescription Drug Transparency Report for measurement year 2024* (SB172024Report). <https://www.dmhc.ca.gov/Portals/0/Docs/DO/SB172024Report.pdf>

³ Schaeffer Center for Health Policy and Economics, University of Southern California. (2018). *Frequency and magnitude of co-payments exceeding prescription drug reimbursement in the United States*. *JAMA*, 319(10), 1045–1047. <https://doi.org/10.1001/jama.2018.0102>

⁴ Cong, M., Chaisson, J., Cantrell, D., Leonard, B. L., Carter, M., Lachance-Bennett, L. S., ... & Wang, H. C. (2021). *Association of co-pay elimination with medication adherence and total cost*. *The American Journal of Managed Care*, 27(6), 249–254. <https://doi.org/10.37765/ajmc.2021.88664>