304.17A-164 Limitations on insurers and pharmacy benefit managers regarding cost-sharing for prescription drugs -- Exceptions.

(1) As used in this section:

(a) "Cost sharing" 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 an individual to receive a specific health care service covered by the plan;

(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 a policy, contract, certificate, or 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 health care services;

(e) "Insurer" 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; or

3. Any employee of a pharmacy or pharmacist; and

(h) "Pharmacy benefit manager" has the same meaning as in 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 pay a cost-sharing amount greater than the amount the insured would pay for the drug if he or she were to purchase the drug without coverage;

(b) 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) of this subsection, when calculating an insured's contribution to any applicable cost-sharing requirement. The requirements of this paragraph shall not apply 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;

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

(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.

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