State PBM Reform Inventory

Updated October 2026

Kentucky

Issue	Summary	Citation
Licensing/Registration	To conduct business in this state, a PBM must first obtain a license from the commissioner. The license shall be in lieu of an administrator's license as required by KRS 304.9-052. A licensed PBM performing utilization review, as defined in KRS 304.17A-600, shall be registered as a private review agent in accordance with KRS 304.17A- 607. A person seeking a PBM license shall apply to the commissioner in writing on a form provided by the department. Each application for a license, and subsequent renewal for a license, shall be accompanied by a nonrefundable fee of $1,000, evidence of financial responsibility in an amount of $1,000,000, and any methodologies utilized, or to be utilized, by the PBM in connection with reimbursement. All licenses shall be renewed annually.	KRS 304.9-053
Reporting Requirements	N/A	
PBM Income	**Spread Pricing (Medicaid):** By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The department shall prohibit the managed Medicaid program's PBM from conducting spread pricing. **Rebate Pass-Through (Medicaid):** By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The department shall require that the managed Medicaid program's PBM utilize pass- through pricing.	KRS 205.5512
Pharmacy Contracting	**MAC Pricing:** The PBM shall ensure that drugs subject to MAC pricing are: • Generally available for purchase by pharmacists and pharmacies in Kentucky from a national or regional wholesaler licensed in Kentucky by the Kentucky Board of Pharmacy;	KRS 304.17A-162; KRS 304.17A-595;

	• Not obsolete, temporarily unavailable, or listed on a drug shortage list; and
	• Drugs that have an "A" or "B" rating in the most recent version of the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book; or rated "NR" or "NA" or have a similar rating by a nationally recognized reference.
	
	The PBM shall:
	• Identify to contracted pharmacies the sources used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the PBM; and
	• Establish a process for contracted pharmacies, pharmacy services administration organizations, or group purchasing organizations to appeal and resolve disputes regarding the MAC pricing. The process shall include the following provisions:
	  ○ The right to appeal shall be limited to 60 days following the initial claim;
	  ○ The appeal shall be investigated and resolved by the PBM within 10 calendar days;
	  ○ The PBM shall respond to all appeals in a manner approved by the department;
	  ○ If the appeal is denied, the PBM shall provide the reason for the denial and identify the NDC of a drug product and source where it may be purchased from a licensed wholesaler by contracted pharmacies at a price at or below the MAC; and
	  ○ If an appeal is granted, the PBM shall:
	  ▪ Make the change in the MAC to the initial date of service the appealed drug was dispensed;
	  ▪ Adjust the MAC of the drug for the appealing pharmacy and for all other contracted pharmacies in the network of that PBM that filled a prescription for patients covered under the same health benefit plan to the initial date of service the appealed drug was dispensed;
	  ▪ Individually notify all other contracted pharmacies in the network of that PBM that a retroactive MAC adjustment has been made as a result of a granted
		KRS 304.17A-597;
		
		KRS 205.5512

	appeal effective to the initial date of service the appealed drug was dispensed; ▪ Adjust the drug product reimbursement for contracted pharmacies that resubmit claims to reflect the adjusted MAC if applicable to their contract; ▪ Allow the appealing pharmacy and all other contracted pharmacies in the network that filled prescriptions for patients covered under the same health benefit plan to reverse and resubmit claims and receive payment based on the adjusted MAC from the initial date of service the appealed drug was dispensed; and ▪ Make retroactive price adjustments in the next payment cycle. **Minimum Reimbursement:** Every contract between a pharmacy or pharmacist and an insurer, a PBM, or any other TPA of pharmacy benefits, either directly or through a PSAO or GPO, shall: • Prohibit reducing payment for pharmacy or pharmacist services, directly or indirectly, under a reconciliation process to an effective rate of reimbursement. • Prohibit reimbursing the pharmacy or pharmacist for a prescription drug or other service at a net amount that is lower than the amount the insurer, PBM, or other administrator reimburses itself or a pharmacy affiliate. An insurer, PBM, or other administrator shall provide the following minimum reimbursement for pharmacy services: • Ingredient costs: Reimbursement for the cost of the drug or other service at an amount that is not less than: ○ The NADAC for the drug or service at the time the drug or service is administered, dispensed, or provided; or ○ If the NADAC is not available at the time a drug is administered or dispensed, the WAC for the drug at the time the drug is administered or dispensed. • The above reimbursement for drug costs shall not apply to pharmacies licensed in the state as “retail chain” until determined by the Insurance Commissioner, no sooner than January 1, 2027.	

	• Professional dispensing fee: For plan years after January 1, 2027, reimbursement for a professional dispensing fee shall be not less than the average cost to dispense a prescription drug in an ambulatory pharmacy setting in Kentucky, as determined by the commissioner.
	  ○ The minimum dispensing fee shall not apply to mail-order pharmacies.
	  ○ For health plan years beginning prior to January 1, 2027, and for any future health plan years for which the commissioner has not established the average dispensing cost, the minimum dispensing fee for a pharmacy permitted as "retail independent" on file with the Kentucky Board of Pharmacy, or a pharmacist practicing at such a pharmacy, shall be not less than $10.64.
	
	Patient Steering:
	An insurer, PBM, or another administrator shall not:
	• Require or incentivize an insured to receive pharmacy or pharmacist services from a pharmacy affiliate. Conduct prohibited under this subparagraph includes but is not limited to:
	  ○ Requiring or incentivizing an insured to obtain a specialty drug from a pharmacy affiliate;
	  ○ Charging less cost sharing to insureds that use pharmacy affiliates than what is charged to insureds that use nonaffiliated pharmacies; and
	  ○ Providing any incentives for insureds that use pharmacy affiliates that are not provided for insureds that use nonaffiliated pharmacies.
	• Require or incentivize an insured to use a mail-order pharmacy.
	• Impose limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate
	
	Patient Steering (Medicaid):
	By December 31, 2020, the Department for Medicaid Services shall select a TPA to serve as the PBM for every MCO that contracts with the department to deliver Medicaid services. The	

	department shall prohibit the managed Medicaid program's PBM from requiring or incentivizing a Medicaid recipient to use a pharmacy owned by or otherwise associated with the state PBM. The department shall also prohibit the state's PBM from requiring a Medicaid recipient to obtain a specialty drug from a specialty pharmacy owned by or otherwise associated with the state PBM.	
Patient Cost-Sharing	**Copay Cap:** All health benefit plans issued or renewed on or after January 1, 2022, shall provide coverage for equipment, supplies, outpatient self-management training and education, including medical nutrition therapy, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items. Cost sharing for a covered prescription insulin drug shall not exceed thirty dollars ($30) per thirty (30) day supply of each prescription insulin drug, regardless of the amount or type of insulin needed to meet the covered person's insulin needs. **Maximum Cost-Sharing Levels:** An insurer issuing or renewing a health plan on or after January 1, 2022, or a PBM, shall not 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 they were to purchase the drug without coverage. **Copay Adjustment Programs:** An insurer issuing or renewing a health plan on or after January 1, 2022, or a PBM, shall not exclude any cost-sharing amounts paid by an insured or on behalf of an insured by another person for a prescription drug when calculating an insured's contribution to any applicable cost-sharing requirement. These requirements shall not apply to 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. These requirements also do	KRS 304.17A-148; KRS 304.17A-164

	not apply to any fully insured health benefit plan or self-insured government employee health plan.	