Proponent Testimony for SB 360, the Kansas Consumer Prescription Protection and Accountability Act

January 28, 2026

Chairwoman Dietrich and Members of the Committee,

Thank you for the opportunity to testify in support of Senate Bill 360.

Pharmacy benefit managers (PBMs) play an important role in managing prescription drug benefits. PBMs negotiate drug prices with manufacturers, determine which medications are covered by health plans, and set reimbursement rates for pharmacies—they wield a significant influence over what patients pay and where they can fill prescriptions. Currently, PBMs in Kansas conduct much of their business behind closed doors. SB 360 establishes a new regulatory framework that ensures their practices are transparent, fair, and aligned with the interests of patients and health plans.

In 2022, Kansas enacted the Kansas Pharmacy Benefit Manager Licensure Act (K.S.A. 40-3821 et seq.) which required licensure of all PBMs operating in Kansas. There are currently 54 licensed PBMs in Kansas. In accordance with the act, the Department requires a $2,500 nonrefundable application fee; Contact and business information; a template contract between a PBM and a pharmacy, or health insurer, with a dispute resolution process included and; a network adequacy report to be submitted along with the application.

The Department has very limited authority to regulate PBMs and even fewer tools to assist Kansans who have complaints regarding PBMs. Consequently, there is little transparency or accountability in areas that directly affect prescription drug costs for Kansans. SB 360 establishes a new regulatory framework that ensures PBM practices are focused on returning savings to Kansans.

Lower Drug Costs and Premiums
Rebates—payments from drug manufacturers in exchange for preferential treatment—obtained by PBMs are entirely unknown and undisclosed in Kansas. There is no requirement for PBMs to disclose how much they receive in rebates, how much they retain, or how much is passed onto health plans or patients. SB 360 addresses this and requires that all rebates be passed through to patients and their health plans. 100% of rebates, credits, and other incentives received by PBMs must be used to reduce out-of-pocket prescription drug costs. Any excess rebates must be used to reduce health insurance premiums.

Fair and Actual Drug Prices
"Spread pricing"—when a PBM bills a health plan more for a prescription than they reimburse the pharmacy—is often hidden from patients and health plans in Kansas. Because there is no requirement to disclose these price differences, health plans likely pay higher costs that do not reflect the true cost of their medications, while PBMs pocket

the "spread" as profit. SB 360 bans spread pricing and ensures that health plans pay the actual cost of the prescription, without any hidden markups.

Protecting Patient Choice and Access
PBM-affiliate pharmacies—pharmacies owned directly or indirectly by PBMs—often receive more favorable reimbursement than non-affiliated pharmacies. This results in unbalanced reimbursement practices that can significantly limit patients' and health plans' access to pharmacies of their choice. SB 360 requires fair and consistent reimbursement regardless of pharmacy affiliation. This protects patient access and ensures that patients can fill prescriptions at pharmacies of their choice, rather than being steered by PBM vertical integration.

Transparency and Accountability
There are currently no requirements for PBMs in Kansas to disclose any data regarding received rebates, retained spread, or how they reimburse non-affiliated pharmacies. In addition to the consumer-centric reforms listed above, SB 360 implements new data reporting requirements, shining a light on PBM practices. Requiring annual and quarterly data submission to the KDOI together with the Department's examination authority effectively guarantees compliance with this legislation. Furthermore, the Department can use this data, together with information from health plans, to identify and confirm where costs have been reduced for health plans in Kansas.

Many states have implemented PBM reforms similar to those found in this bill including West Virginia, Arkansas, Alabama, Florida, Idaho, Utah, etc. The types of provisions in SB 360 have been upheld by federal courts. The provisions stay within the guidelines allowed by the U.S. Supreme Court[1] and the 10th Circuit Court of Appeals[2], which reduces the likelihood of any successful litigation against the law.

Opponents of this bill will tell you these reforms will cause rates to go up. West Virginia found this not to be the case. Specifically, their data showed that traditional increases in annual health insurance rates were lowered because of the PBM reforms. In some cases, this was by as much as half. Find attached the West Virginia Insurance Bulletin 25-01. Issued on February 13, 2025, this report includes anonymized data and illustrates how traditional rate increases were mitigated.

PBMs play a powerful role in determining what patients pay for prescription drugs, yet in Kansas their practices are near unregulated and cost taxpayers and health plans more. The Department respectfully requests your thoughtful consideration of this legislation to lower costs for Kansans.

Vicki Schmidt
Commissioner of Insurance

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[1] *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80, 141 S.Ct.474 (2020)
[2] *Pharmaceutical Care Management Association v. Mulready*, 78 F. 4th 1183 (2023)

WEST VIRGINIA INSURANCE BULLETIN
No. 25-01

Insurance Bulletins are issued when the Commissioner renders formal opinions, guidance or expectations on matters or issues, explains how new statutes or rules will be implemented or applied, or advises of interpretation or application of existing statutes or rules.

► Prescription Drug Rebate Impact to Commercial Health Insurance◄

In 2021, the Legislature passed House Bill 2263 amending West Virginia's *Pharmacy Audit Integrity Act* (PAIA) located in Chapter 33, Article 51 of the *West Virginia Code*. The 2021 updates to the PAIA generally went into effect on January 1, 2022. One of the more substantive updates to the law was regarding prescription drug rebates. The West Virginia Offices of the Insurance Commissioner (OIC) is issuing this Insurance Bulletin to publicly provide frequently requested information regarding the effects of the prescription drug rebate law on health insurance rates as reported by commercial health insurers to the OIC.

W.Va. Code §33-51-9(k) provides "a covered individual's defined cost sharing for each prescription drug shall be calculated at the point of sale based on a price that is reduced by an amount equal to at least 100 percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug. ***Any rebate over and above the defined cost sharing would then be passed on to the health plan to reduce premiums***." (emphasis added).[1] This provision of the PAIA is oftentimes referred to as the "point-of-sale" or "pass-through rebate" provision. Any rebate calculated by a pharmacy benefit manager (PBM) to be over and above a covered individual's defined cost sharing may not be retained by the PBM but must be passed on to the health benefit plan and must be used by the health benefit plan to reduce the cost of premiums. *See* W.Va. Code St. R. §114-99-5.14.3.

Beginning in 2023, the OIC asked health insurers who file rates with the OIC to calculate the total amount of rebates received on prescription drugs and to assess the impact thereof on health insurance rates. Health insurers have been asked to separate the rate effect due to West Virginia's prescription drug rebate law from the health insurer's otherwise filed rate request without the effect of the prescription drug rebate law. Health insurers have complied and provided the OIC with the percentage that their annual rate request was reduced due to receipt of prescription drug rebates. Data submitted to the OIC by the health insurers is subsequently reviewed by OIC contracted actuaries.[2] Health insurers who have submitted this information in their annual filings are Aetna Health Insurance Company, CareSource West Virginia Company, Highmark Blue Cross Blue Shield, The Health Plan of West Virginia, THP Insurance Company, UnitedHealthcare Insurance Company, and Optimum Choice, Inc.

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[1] W.Va. Code §33-51-3 defines "defined cost sharing" as "a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan."

[2] The OIC does not currently possess specific data on how rebates affected the rate filings of specific insurers prior to 2022. Prior to the implementation of the point-of-sale or pass-through rebate law, PBMs and health insurers were able to negotiate rebate contract terms. Some insurers may have required 100% of rebates to be passed through to the insurer, while other insurers may have allowed their PBM to retain rebates, or portions thereof, as part of the PBM's compensation.

2023 Filings (2024 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	17.10%	-5.50%	11.60%
Company A	Large Group	16.20%	-5.50%	10.70%
Company B	Individual	6.10%	-3.10%	3.00%
Company C	Individual	10.40%	-8.30%	2.10%
Company C	Small Group	13.50%	-7.10%	6.40%
Company C	Large Group	9.60%	-1.80%	7.80%
Company D	Individual	6.57%	-6.72%	-0.15%
Company D	Small Group	16.18%	-6.28%	9.90%
Company E	Small Group	6.41%	-5.55%	0.86%
Company F	Small Group	29.60%	-14.00%	15.60%
Company G	Small Group	29.40%	-14.00%	15.40%

2024 Filings (2025 Plan Year):

Insurer	Plan Type	Rate Change Without Pass-Through Rebate	Pass-Through Rebate Effect on Rate	Final Rate Change
Company A	Any Size	18.80%	-6.20%	12.60%
Company A	Large Group	18.70%	-6.20%	12.50%
Company B	Individual	15.097%	-2.75%	12.347%
Company C	Individual	12.30%	-9.60%	2.70%
Company C	Small Group	17.60%	-9.67%	7.93%
Company C	Large Group	17.30%	-0.70%	16.60%
Company C	Transitional	18.90%	-10.30%	8.60%
Company D	Individual	7.72%	-7.45%	0.27%
Company D	Small Group	17.80%	-7.07%	10.73%
Company E	Small Group	11.89%	-7.60%	4.29%
Company F	Small Group	21.80%	-11.70%	10.10%
Company F	Large Group	5.21%	0.00%	5.21%
Company G	Small Group	21.900%	-11.70%	10.200%

Please e-mail any questions concerning this Insurance Bulletin to OICBulletins@wv.gov.

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