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LEGISLATURE OF NEBRASKA

ONE HUNDRED SEVENTH LEGISLATURE

FIRST SESSION

LEGISLATIVE BILL 270

Introduced by Morfeld, 46.

Read first time January 12, 2021

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to pharmacy benefits; to amend sections 68-901 and 71-2484, Revised Statutes Cumulative Supplement, 2020; to adopt the Pharmacy Benefit Manager Regulation Act; to transfer provisions related to pharmacy benefits; to require an audit as prescribed; to harmonize provisions; to provide a duty for the Revisor of Statutes; to repeal the original sections; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

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Section 1. Sections 1 to 12 of this act shall be known and may be cited as the Pharmacy Benefit Manager Regulation Act.

Sec. 2. Section 71-2484, Revised Statutes Cumulative Supplement, 2020, is amended to read:

~~71-2484 (1)~~ For purposes of the Pharmacy Benefit Manager Regulation Act ~~this section~~:

(1) Clean claim means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents prompt payment of the claim from being made under the Pharmacy Benefit Manager Regulation Act;

(2) ~~(a)~~ Contracted pharmacy means a pharmacy located in this state that participates either in the network of a pharmacy benefit manager or in a health care or pharmacy benefits management plan through a direct contract or through a contract with a pharmacy services administration organization, a group purchasing organization, or another contracting agent;

(3) ~~(b)~~ Covered entity means (a) ~~(i)~~ a nonprofit hospital or medical services corporation, an insurer, a third-party payor, a managed care company, or a health maintenance organization, (b) ~~(ii)~~ a health program administered by the state in the capacity of provider of health insurance coverage, or (c) ~~(iii)~~ an employer, a labor union, or any other group of persons organized in the state that provides health insurance coverage;

(4) ~~(c)~~ Covered individual means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a covered entity who is provided health insurance coverage by the covered entity and includes a dependent or other person provided health insurance coverage through a policy, contract, or plan for a covered individual;

(5)(a) ~~(d)(i)~~ Insurer means any person providing life insurance, sickness and accident insurance, workers' compensation insurance, or annuities in this state.

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(b) ~~(ii)~~ Insurer includes an authorized insurance company, a prepaid hospital or medical care plan, a managed care plan, a health maintenance organization, any other person providing a plan of insurance subject to state insurance regulation, and an employer who is approved by the Nebraska Workers' Compensation Court as a self-covered entity;

(6) ~~(e)~~ Pharmacist has the same meaning as in section 38-2832;

(7) ~~(f)~~ Pharmacy has the same meaning as in section 71-425;

(8) ~~(g)~~ Pharmacy benefit manager means a person or an entity that performs pharmacy benefits management services for a covered entity and includes any other person or entity acting on behalf of a pharmacy benefit manager pursuant to a contractual or employment relationship;

(9) ~~(h)~~ Pharmacy benefits management means the administration or management of prescription drug benefits provided by a covered entity under the terms and conditions of the contract between the pharmacy benefit manager and the covered entity; ~~and~~

(10) ~~(i)~~ Prescription drug means a prescription drug or device or legend drug or device as defined in section 38-2841; and ~~.~~

(11) Spread pricing means the model of prescription drug pricing in which (a) the pharmacy benefit manager charges a covered entity a contracted price for prescription drugs and (b) the contracted price for the prescription drugs differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

~~(2) A pharmacist or contracted pharmacy shall not be prohibited from or subject to penalties or removal from a network or plan for sharing information regarding the cost, price, or copayment of a prescription drug with a covered individual or a covered individual's caregiver. A pharmacy benefit manager shall not prohibit or inhibit a pharmacist or contracted pharmacy from discussing any such information or selling a more affordable alternative to a covered individual or a covered individual's caregiver.~~

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~~(3) An insurer that offers a health plan which covers prescription drugs shall not require a covered individual to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:~~

~~(a) The covered individual's copayment, deductible, or coinsurance for such prescription drug; or~~

~~(b) The amount any individual would pay for such prescription drug if that individual paid in cash.~~

Sec. 3. (1) A pharmacist or contracted pharmacy shall not be prohibited from or subject to penalties or removal from a network or plan for sharing information regarding the cost, price, or copayment of a prescription drug with a covered individual or a covered individual's caregiver. A pharmacy benefit manager shall not prohibit or inhibit a pharmacist or contracted pharmacy from discussing any such information or selling a more affordable alternative to a covered individual or a covered individual's caregiver.

(2) An insurer that offers a health plan which covers prescription drugs shall not require a covered individual to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The covered individual's copayment, deductible, or coinsurance for such prescription drug; or

(b) The amount any individual would pay for such prescription drug if that individual paid in cash.

Sec. 4. (1) A pharmacy benefit manager shall not exclude a pharmacy from participation in its specialty pharmacy network. A licensed pharmacy or a licensed pharmacist may dispense prescription drugs that are allowed pursuant to the license.

(2) Covered individuals who use a mail-order pharmacy shall not be charged fees or higher copays to utilize a contracted pharmacy. A pharmacy benefit manager shall not prohibit a pharmacist or contracted

pharmacy from mailing a prescription drug to a covered individual.

Sec. 5. A pharmacy benefit manager shall not charge a pharmacist or pharmacy a fee related to the adjudication of a claim, retroactively deny or reduce a claim of a pharmacist or pharmacy for payment, or demand repayment of all or part of a claim if the claim submitted was a clean claim.

Sec. 6. A pharmacy benefit manager shall not directly or indirectly engage in any practice that directs or influences a covered individual to use a pharmacy in which the pharmacy benefit manager maintains an ownership interest or control without making a written disclosure and receiving acknowledgment from the covered individual. The disclosure shall provide notice that the pharmacy benefit manager has an ownership interest in or control of the pharmacy and that the covered individual has the right under the law to use any alternate pharmacy that the covered individual chooses. The pharmacy benefit manager is prohibited from retaliation or further attempts to influence the covered individual or treat the covered individual's claim any differently if the covered individual chooses to use the alternate pharmacy.

Sec. 7. A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist an amount less than the amount that the pharmacy benefit manager reimburses a pharmacy-benefit-manager-owned pharmacy for providing the same drug, calculated on a per-unit basis using the same generic product identifier or generic code number and reflecting all drug manufacturer's rebates, direct and indirect administrative fees, costs, and any remuneration.

Sec. 8. (1) A pharmacy benefit manager that reimburses a 340B entity for drugs that are subject to an agreement under 42 U.S.C. 256b shall not reimburse the 340B entity for pharmacy-dispensed drugs at a rate lower than that paid for the same drug to pharmacies similar in prescription volume that are not 340B entities, and shall not assess any fee, chargeback, or other adjustment upon the 340B entity on the basis

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that the 340B entity participates in the program set forth in 42 U.S.C. 256b.

(2) With respect to a covered individual eligible to receive drugs subject to an agreement under 42 U.S.C. 256b, a pharmacy benefit manager shall not discriminate against a 340B entity in a manner that prevents or interferes with the covered individual's choice to receive such drugs from the 340B entity.

(3) For purposes of this section, 340B entity means an entity participating in the federal 340B drug discount program, as described in 42 U.S.C. 256b, including its pharmacy or pharmacies, or any pharmacy or pharmacies, contracted with the participating entity to dispense drugs purchased through such program.

Sec. 9. (1) Any insurer on its own or through its contracted pharmacy benefit manager or representative of a pharmacy benefit manager shall not conduct spread pricing in Nebraska on any prescription drug paid with state or federal funds and shall ensure that before a particular prescription drug is placed or continues to be placed on a maximum allowable cost list, the prescription drug must:

(a) Be listed as "A" or "B" rated in the most recent version of the federal Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, or have an "NR" or "NA" rating, or a similar rating by a nationally recognized reference;

(b) Be available for purchase in Nebraska from national or regional wholesalers operating in Nebraska; and

(c) Not be obsolete and must be eligible for a rebate in the medical assistance program.

(2) Any insurer on its own or through its contracted pharmacy benefit manager or representative of a pharmacy benefit manager shall:

(a) Provide a process for a network pharmacy provider to readily access the maximum allowable cost specific to that provider;

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(b) Update its maximum allowable cost list at least once every seven calendar days;

(c) Provide a process for each pharmacy subject to the maximum allowable cost list to access any updates to the maximum allowable cost list; and

(d) Establish a reasonable administrative appeal procedure by which a contracted pharmacy may appeal the provider's reimbursement for a prescription drug subject to maximum allowable cost pricing if the reimbursement for the prescription drug is less than the net amount that the provider paid to the supplier of the prescription drug. The reasonable administrative appeal procedure shall include:

(i) A dedicated telephone number and email address or web site for the purpose of submitting administrative appeals; and

(ii) The ability to submit an administrative appeal directly to the pharmacy benefit manager regarding the pharmacy benefits plan or program or through a pharmacy service administrative organization if the pharmacy service administrative organization has a contract with the pharmacy benefit manager that allows for the submission of such appeals.

(3) A pharmacy shall be allowed no less than ten calendar days after the applicable fill date to file an administrative appeal.

(4) If an appeal is initiated, the insurer either directly or through its pharmacy benefit manager shall within ten calendar days after receipt of notice of the appeal either:

(a) If the appeal is upheld:

(i) Notify the pharmacy, the pharmacist, or the designee of the pharmacist of the decision;

(ii) Make the change in the maximum allowable cost effective as of the date the appeal is resolved;

(iii) Permit the appealing pharmacy or pharmacist to reverse and rebill the claim in question; and

(iv) Make the change effective for each similarly situated pharmacy

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as defined by the payor subject to the maximum allowable cost list effective as of the date the appeal is resolved; or

(b) If the appeal is denied, provide the appealing pharmacy or pharmacist the reason for the denial, the National Drug Code number of a prescription drug product that is at or below the calculated reimbursement, and the name of the national or regional pharmaceutical wholesaler operating in Nebraska where the prescription drug can be purchased at or below the reimbursed cost.

Sec. 10. When calculating a covered individual's contribution to any applicable cost-sharing requirement, an insurer shall include any cost-sharing amounts paid by the covered individual or on behalf of the covered individual by another person. If in any situation the requirement of this section is invalid or incapable of being enforced against an insurer due to a conflict with federal requirements, the requirement shall remain in full force and effect with respect to all insurers and in all situations in which no such conflict exists. If the application of the requirement would be the sole cause of a state-regulated high deductible health plan's failure to qualify as such a plan under section 223 of the Internal Revenue Code of 1986, the requirement shall not apply to such a plan to the extent necessary to avoid that result.

Sec. 11. For each county in which an insurer offers health plans, an insurer shall offer only health plans that:

(1) Do not require a covered individual to pay a deductible for prescription drugs covered by the health plan; and

(2) Provide that the amount of cost-sharing paid by a covered individual for any given prescription drug shall not exceed the amount of the copayment or coinsurance specified in the summary of benefits and coverage for the health plan.

Sec. 12. When calculating a covered individual's contribution to any applicable cost-sharing requirement, a pharmacy benefit manager shall include any cost-sharing amounts paid by the covered individual or on

behalf of the covered individual by another person. If in any situation this section is invalid or incapable of being enforced against a pharmacy benefit manager due to a conflict with federal law requirements, this section shall remain in full force and effect with respect to all pharmacy benefit managers and in all situations in which no such conflict exists. If the application of this section would be the sole cause of a state-regulated high-deductible health plan's failure to qualify as such a plan under section 223 of the Internal Revenue Code of 1986, this section shall not apply to such a plan to the extent necessary to avoid that result.

Sec. 13. Section 68-901, Revised Statutes Cumulative Supplement, 2020, is amended to read:

68-901 Sections 68-901 to 68-9,100 and section 14 of this act shall be known and may be cited as the Medical Assistance Act.

Sec. 14. The Auditor of Public Accounts shall, prior to January 1, 2022, conduct an audit of the pharmacy benefit of the medical assistance program under the Medical Assistance Act from January 1, 2018, through December 31, 2020. The audit shall compare the costs of the pharmacy benefit under the medical assistance program in a fee-for-service model with a managed care model. All fees, spread pricing, rebates, and other costs associated with the managed care pharmacy benefit shall be considered. It is the intent of the Legislature to pay for the audit using the excess funds returned to the State of Nebraska from the managed care organizations.

Sec. 15. The Revisor of Statutes shall assign sections 1 to 12 of this act to Chapter 44, article 7.

Sec. 16. Original sections 68-901 and 71-2484, Revised Statutes Cumulative Supplement, 2020, are repealed.

Sec. 17. Since an emergency exists, this act takes effect when passed and approved according to law.