

LEGISLATURE OF NEBRASKA
ONE HUNDRED SEVENTH LEGISLATURE
FIRST SESSION

LEGISLATIVE BILL 678

Introduced by Linehan, 39.

Read first time January 20, 2021

Committee: Banking, Commerce and Insurance

- 1 A BILL FOR AN ACT relating to pharmacy benefits; to amend sections 68-901
- 2 and 71-2484, Revised Statutes Cumulative Supplement, 2020; to adopt
- 3 the Pharmacy Benefit Manager Regulation Act; to transfer provisions
- 4 related to pharmacy benefits; to require an audit as prescribed; to
- 5 harmonize provisions; to provide a duty for the Revisor of Statutes;
- 6 to repeal the original sections; and to declare an emergency.
- 7 Be it enacted by the people of the State of Nebraska,

1 Section 1. Sections 1 to 11 of this act shall be known and may be
2 cited as the Pharmacy Benefit Manager Regulation Act.

3 Sec. 2. Section 71-2484, Revised Statutes Cumulative Supplement,
4 2020, is amended to read:

5 ~~71-2484 (1)~~ For purposes of the Pharmacy Benefit Manager Regulation
6 Act this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 pharmacy from mailing a prescription drug to a covered individual.

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

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

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

26 Sec. 8. (1) Any insurer on its own or through its contracted
27 pharmacy benefit manager or representative of a pharmacy benefit manager
28 shall not conduct spread pricing in Nebraska on any prescription drug
29 paid with state or federal funds and shall ensure that before a
30 particular prescription drug is placed or continues to be placed on a
31 maximum allowable cost list, the prescription drug must:

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

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

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

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

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

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

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

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

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

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

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

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

6 (a) If the appeal is upheld:

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

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

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

13 (iv) Make the change effective for each similarly situated pharmacy
14 as defined by the payor subject to the maximum allowable cost list
15 effective as of the date the appeal is resolved; or

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

22 Sec. 9. When calculating a covered individual's contribution to any
23 applicable cost-sharing requirement, an insurer shall include any cost-
24 sharing amounts paid by the covered individual or on behalf of the
25 covered individual by another person. If in any situation the requirement
26 of this section is invalid or incapable of being enforced against an
27 insurer due to a conflict with federal requirements, the requirement
28 shall remain in full force and effect with respect to all insurers and in
29 all situations in which no such conflict exists. If the application of
30 the requirement would be the sole cause of a state-regulated high
31 deductible health plan's failure to qualify as such a plan under section

1 223 of the Internal Revenue Code of 1986, the requirement shall not apply
2 to such a plan to the extent necessary to avoid that result.

3 Sec. 10. For each county in which an insurer offers health plans,
4 an insurer shall offer only health plans that:

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

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

11 Sec. 11. When calculating a covered individual's contribution to
12 any applicable cost-sharing requirement, a pharmacy benefit manager shall
13 include any cost-sharing amounts paid by the covered individual or on
14 behalf of the covered individual by another person. If in any situation
15 this section is invalid or incapable of being enforced against a pharmacy
16 benefit manager due to a conflict with federal law requirements, this
17 section shall remain in full force and effect with respect to all
18 pharmacy benefit managers and in all situations in which no such conflict
19 exists. If the application of this section would be the sole cause of a
20 state-regulated high-deductible health plan's failure to qualify as such
21 a plan under section 223 of the Internal Revenue Code of 1986, this
22 section shall not apply to such a plan to the extent necessary to avoid
23 that result.

24 Sec. 12. Section 68-901, Revised Statutes Cumulative Supplement,
25 2020, is amended to read:

26 68-901 Sections 68-901 to 68-9,100 and section 13 of this act shall
27 be known and may be cited as the Medical Assistance Act.

28 Sec. 13. The Auditor of Public Accounts shall, prior to January 1,
29 2022, conduct an audit of the pharmacy benefit of the medical assistance
30 program under the Medical Assistance Act from January 1, 2018, through
31 December 31, 2020. The audit shall compare the costs of the pharmacy

1 benefit under the medical assistance program in a fee-for-service model
2 with a managed care model. All fees, spread pricing, rebates, and other
3 costs associated with the managed care pharmacy benefit shall be
4 considered. It is the intent of the Legislature to pay for the audit
5 using the excess funds returned to the State of Nebraska from the managed
6 care organizations.

7 Sec. 14. The Revisor of Statutes shall assign sections 1 to 11 of
8 this act to Chapter 44, article 7.

9 Sec. 15. Original sections 68-901 and 71-2484, Revised Statutes
10 Cumulative Supplement, 2020, are repealed.

11 Sec. 16. Since an emergency exists, this act takes effect when
12 passed and approved according to law.