

LEGISLATURE OF NEBRASKA
ONE HUNDRED SIXTH LEGISLATURE
SECOND SESSION

LEGISLATIVE BILL 1196

Introduced by Morfeld, 46.

Read first time January 23, 2020

Committee:

1 A BILL FOR AN ACT relating to pharmacy benefits; to amend sections 68-901
2 and 71-2484, Revised Statutes Supplement, 2019; to adopt the
3 Pharmacy Benefit Manager Regulation Act; to transfer provisions
4 related to pharmacy benefits; to require an audit as prescribed; to
5 provide a duty for the Revisor of Statutes; to repeal the original
6 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 Supplement, 2019, is
4 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 the pharmacy benefit manager charges a covered entity a contracted
20 price for prescription drugs, and the contracted price for the
21 prescription drugs differs from the amount the pharmacy benefit manager
22 directly or indirectly pays the pharmacist or pharmacy for pharmacist
23 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 or retroactively
4 deny 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 patient to use a
9 pharmacy in which the pharmacy benefit manager maintains an ownership
10 interest or control without making a written disclosure and receiving
11 acknowledgment from the patient. The disclosure shall provide notice that
12 the pharmacy benefit manager has an ownership interest in or control of
13 the pharmacy and that the patient has the right under the law to use any
14 alternate pharmacy that the patient chooses. The pharmacy benefit manager
15 is prohibited from retaliation or further attempts to influence the
16 patient or treat the patient or the patient's claim any differently if
17 the patient chooses to use the alternate pharmacy.

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

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

31 (a) Be listed as "A" or "B" rated in the most recent version of the

1 federal Food and Drug Administration's Approved Drug Products with
2 Therapeutic Equivalence Evaluations, also known as the Orange Book, or
3 has an "NR" or "NA" rating, or a similar rating by a nationally
4 recognized reference;

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

7 (c) Not be obsolete and must be rebateable in the medical assistance
8 program.

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

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

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

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

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

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

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

31 (3) A pharmacy shall be allowed no less than ten calendar days after

1 the applicable fill date to file an administrative appeal.

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

5 (a) If the appeal is upheld:

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

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

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

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

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

20 Sec. 9. When calculating an enrollee's contribution to any
21 applicable cost-sharing requirement, a health carrier shall include any
22 cost-sharing amounts paid by the enrollee or on behalf of the enrollee by
23 another person. If in any situation the requirement of this section is
24 invalid or incapable of being enforced against a health carrier due to a
25 conflict with federal requirements, the requirement shall remain in full
26 force and effect with respect to all health carriers and in all
27 situations in which no such conflict exists. If the application of the
28 requirement would be the sole cause of a state-regulated high deductible
29 health plan's failure to qualify as such a plan under section 223 of the
30 federal Internal Revenue Code of 1986, the requirement shall not apply to
31 such a plan to the extent necessary to avoid that result.

1 Sec. 10. For each county in which a health carrier offers health
2 plans, a health carrier shall offer only health plans that:

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

5 (2) Provide that the amount of cost-sharing paid by an enrollee for
6 any given prescription drug shall not exceed the amount of the copayment
7 or coinsurance specified in the summary of benefits and coverage for the
8 health plan.

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

22 Sec. 12. Section 68-901, Revised Statutes Supplement, 2019, is
23 amended to read:

24 68-901 Sections 68-901 to 68-994 and section 13 of this act shall be
25 known and may be cited as the Medical Assistance Act.

26 Sec. 13. The Auditor of Public Accounts shall, prior to January 1,
27 2021, conduct an audit of the pharmacy benefit of the medical assistance
28 program under the Medical Assistance Act from January 1, 2017, through
29 December 31, 2019. The audit shall compare the costs of the pharmacy
30 benefit under the medical assistance program in fee-for-service model
31 with a managed care model. All fees, spread pricing, rebates, and other

1 costs associated with the managed care pharmacy benefit shall be
2 considered. It is the intent of the Legislature to pay for the audit
3 using the excess funds from the managed care organizations that were
4 returned to the State of Nebraska.

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

7 Sec. 15. Original sections 68-901 and 71-2484, Revised Statutes
8 Supplement, 2019, are repealed.

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