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LEGISLATURE OF NEBRASKA

ONE HUNDRED SEVENTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 718

Introduced by Morfeld, 46.

Read first time January 05, 2022

Committee:

A BILL FOR AN ACT relating to health care benefits; to define terms; to provide requirements for cost-sharing and coverage; to provide for applicability; to provide for rules and regulations; and to provide a duty for the Revisor of Statutes.

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

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Section 1. (1) For purposes of this section:

(a) Cost-sharing requirement means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including, but not limited to, a limitation subject to 42 U.S.C. 18022(c) and 300gg-6(b), as such sections existed on January 1, 2022, required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan;

(b) Defined cost-sharing means a deductible payment or coinsurance amount imposed on an enrollee for a covered prescription drug under the enrollee's health plan;

(c) Enrollee means any individual entitled to health care services from a health carrier;

(d) Health care service means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(e) Health carrier means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. 300gg-91, as such section existed on January 1, 2022, or any state or local governmental employer plan;

(f) Health plan means a policy, contract, certification, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(g) Person means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency;

(h) Price-protection rebate means a negotiated price concession that accrues, directly or indirectly, to the health carrier or other party on behalf of the health carrier, in the event of an increase in the

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wholesale acquisition cost of a drug above a specified threshold; and

(i) Rebate means:

(i) Negotiated price concessions including, but not limited to, base price concessions, whether described as a rebate or otherwise, and reasonable estimates of any price-protection rebates and performance-based price concessions that may accrue directly or indirectly to the health carrier during the coverage year from a manufacturer, dispensing pharmacy, or other party in connection with the dispensing or administration of a prescription drug; and

(ii) Reasonable estimates of any negotiated price concessions, fees, and other administrative costs that are passed through, or are reasonably anticipated to be passed through, to the health carrier and serve to reduce the health carrier's liabilities for a prescription drug.

(2) An enrollee'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 eighty percent of all rebates received, or to be received, in connection with the dispensing or administration of the prescription drug.

(3) When calculating an enrollee's contribution to any applicable cost-sharing requirement, a health carrier shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If, under federal law, application of this requirement would result in the ineligibility of a health savings account under section 223 of the Internal Revenue Code of 1986, the requirement shall apply to a health savings account qualified high deductible health plan with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223 of the Internal Revenue Code of 1986, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the Internal Revenue Code of 1986, in which case the requirements of this subsection shall apply regardless of whether the minimum deductible under section 223 of the

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Internal Revenue Code of 1986 has been satisfied.

(4) Nothing in this section shall preclude a health carrier from decreasing an enrollee's defined cost-sharing by an amount greater than that required under subsection (2) of this section.

(5) This section shall apply to health plans that are entered into, amended, extended, or renewed on or after January 1, 2023.

(6) In implementing the requirements of this section, the state shall only regulate a health carrier to the extent permissible under applicable law.

(7) If, after a department hearing, the Director of Insurance finds a health carrier has violated the requirements of this section, the director shall reduce the findings to writing and shall issue and cause to be served upon the health carrier charged with the violation, a copy of the findings and an order requiring the health carrier to cease and desist from engaging in such violation. The director may also order any one or more of the following:

(a) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the requirements of this section, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(b) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

(8) In complying with the provisions of this section, a health carrier or its agents shall not publish or otherwise reveal information regarding the actual amount of rebates a health carrier receives on a product or therapeutic class of products, a manufacturer, or a pharmacy-specific basis. Such information is protected as a trade secret, is not a

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public record under sections 84-712 to 84-712.09, and shall not be disclosed directly or indirectly, or in a manner that would allow for the identification of an individual product, therapeutic class of products, or manufacturer, or in a manner that would have the potential to compromise the financial, competitive, or proprietary nature of the information. A health carrier shall impose the confidentiality protections of this section on any vendor or third party that performs health care or administrative services on behalf of the health carrier that may receive or have access to rebate information.

(9) The Department of Insurance may adopt and promulgate rules and regulations necessary to carry out this section.

Sec. 2. (1) For purposes of this section:

(a) Cost-sharing requirement means any copayment, coinsurance, deductible, or annual limitation on cost-sharing, including, but not limited to, a limitation subject to 42 U.S.C. 18022(c) and 300gg-6(b), as such sections existed on January 1, 2022, required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan;

(b) Enrollee means any individual entitled to health care services from a health carrier;

(c) Health care service means an item or service furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability;

(d) Health carrier means any health insurance issuer that is subject to state law regulating insurance and offers health insurance coverage, as defined in 42 U.S.C. 300gg-91, as such section existed on January 1, 2022, or any state or local governmental employer plan;

(e) Health plan means a policy, contract, certification, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

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(f) Person means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency.

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

(h) Pharmacy benefits management means the administration or management of prescription drug benefits provided by a health plan under the terms and conditions of the contract or other arrangement between the pharmacy benefit manager and the health plan. Pharmacy benefits management includes, but is not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, or controlling the cost of covered prescription drugs.

(2) When calculating an enrollee's contribution to any applicable cost-sharing requirement, a pharmacy benefit manager shall include any cost-sharing amounts paid by the enrollee or on behalf of the enrollee by another person. If, under federal law, application of this requirement would cause a health savings account qualified high deductible health plan to fail to qualify as such a plan under section 223 of the Internal Revenue Code of 1986, this requirement shall apply with respect to the deductible of such a plan after the enrollee has satisfied the minimum deductible under section 223 of the Internal Revenue Code of 1986, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the Internal Revenue Code of 1986, in which case the requirements of this subsection shall apply regardless of

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whether the minimum deductible under section 223 of the Internal Revenue Code of 1986 has been satisfied.

(3) This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2023.

(4) In implementing the requirements of this section, the state shall only regulate a pharmacy benefit manager to the extent permissible under applicable law.

(5) The Department of Health and Human Services may adopt and promulgate rules and regulations necessary to carry out this section.

Sec. 3. The Revisor of Statutes shall assign section 1 of this act to Chapter 44, article 7 and section 2 of this act to Chapter 71, article 24.