ONE HUNDRED NINTH LEGISLATURE - FIRST SESSION - 2025
COMMITTEE STATEMENT
LB198

Hearing Date: Monday March 03, 2025
Committee On: Banking, Commerce and Insurance
Introducer: Sorrentino
One Liner: Change provisions of the Pharmacy Benefit Manager Licensure and Regulation Act

Roll Call Vote - Final Committee Action:
Advanced to General File with amendment(s)

Vote Results:

Aye:	8	Senators Jacobson, Bostar, Dungan, Hallstrom, Hardin, Riepe, von Gillern, Wordekemper
Nay:		
Absent:		
Present Not Voting:		

Testimony:

Proponents:	**Representing:**
Senator Tony Sorrentino	Opening Presenter
David Randolph	Dave's Pharmacies
Jeff Kilborn	Elmwood Pharmacy
David Kohll	Nebraska Pharmacists Association
Katie Trambly	Self
Jared Glinn	Medicine Man Pharmacy
Alex Byrnes	Hy-Vee
Sarah Kuhl	Nebraska Medicine, Nebraska Hospital Association
Haley Pertzborn	Nebraska Pharmacists Association

Opponents:	**Representing:**
Bill Head	Pharmaceutical Care Management Association
Michelle Crimmins	Prime Therapeutics
Jeremiah Blake	Blue Cross Blue Shield Nebraska
Robert Bell	Nebraska Insurance Federation

Neutral:	**Representing:**

* ADA Accommodation Written Testimony

Summary of purpose and/or changes:
LB 198 would strengthen the regulation of Pharmacy Benefit Managers (PBMs) in Nebraska by expanding the Pharmacy Benefit Manager Licensure and Regulation Act (Act).

Section-by-Section Summary:

Section 1: Adds new sections 4 to 7 of LB 198 to the Act.

Section 2: Amends Neb. Rev. Stat. § 44-4603 by adding five (5) new definitions and by expanding the definition of “health benefit plan” to also include a policy, contract, certificate, plan, or agreement entered into, offered, or issued by a plan sponsor.

Section 3: Amends Neb. Rev. Stat. § 44-4608, which deals with disputes between PBMs and pharmacies. Specifically the section adds the following new requirements:

- Mandates that contracts between PBMs and pharmacies also include a formal process for pharmacies to appeal, investigate, and resolve disputes related to Maximum Allowable Cost (MAC) reimbursements. Currently, the section only provides such a formal process for disputes related to MAC prices, not reimbursements. The process would also be expanded to address instances where the MAC pricing either fails to meet the legal requirements of this section or falls below the pharmacy's actual acquisition cost for the drug.

- Expands the specific procedures for PBMs when addressing pharmacy appeals related to MAC pricing. Under current law, should a PBM deny an appeal, it must furnish a detailed explanation and provide the National Drug Code (NDC) of a drug available for purchase at or below the PBM's established MAC price. Under the bill, if the pharmacy demonstrates that the designated NDC is not procurable from its primary wholesaler at or below the MAC price, the PBM is obligated to rectify the situation by adjusting the MAC price to exceed the appealing pharmacy's acquisition cost and permitting the pharmacy to reverse and rebill any claims impacted by the previously inaccurate MAC pricing, ensuring pharmacies are not forced to dispense medications at a loss.

- Adds to the specific actions a PBM must take when a pharmacy successfully appeals a MAC price. The PBM would have to adjust the MAC price within 1 day of resolving the appeal, provide the pharmacy with the NDC number that justifies the price adjustment, and apply the same adjustment to all similarly situated pharmacies affected by that MAC price list.

Section 4: A new section that restricts PBMs from imposing pharmacy accreditation or recertification standards for network participation that exceed existing federal and state pharmacy licensing requirements, except as provided in Neb. Rev. Stat. § 44-4610. Essentially, PBMs could not create stricter rules for pharmacies to join their networks beyond what is already legally mandated.

Section 5: A new section that establishes financial protections for pharmacies and pharmacists by mandating equal reimbursement practices from PBMs. Specifically, PBMs would be prohibited from reimbursing non-affiliated pharmacies or pharmacists at rates lower than those paid to their own affiliated entities for identical pharmacist services, with calculations based on a per-unit basis and consistent generic drug identification. Furthermore, the section would empower pharmacies to decline dispensing medications if the PBM's MAC pricing results in reimbursement below the pharmacy's acquisition cost, effectively preventing pharmacies from incurring financial losses on providing pharmacist services. PBMs would also be prohibited from directly or indirectly engaging in patient steering to a PBM affiliate.

Section 6: Mandates that PBMs adhere to a "pharmacy benefit manager duty," (defined in Neb. Rev. Stat. § 44-4603) requiring them to act in the best interests of covered individuals, health benefit plans, and providers. This duty encompasses obligations of care, good faith, and fair dealing, with specific rules and regulations to be established by the Director of the Department of Insurance to ensure transparency in areas such as formulary design, utilization management, grievance procedures, and pricing, including the disclosure of all conflicts of interest. Notably, the

PBM's duty to covered individuals would take precedence over its duty to other parties, and its duty to providers takes priority over its duty to health benefit plans, establishing a clear hierarchy of responsibility.

Section 7: A new section that eliminates spread pricing within Nebraska's pharmaceutical benefit system. It explicitly forbids PBMs, health carriers, and health benefit plans from engaging in, facilitating, or contracting for spread pricing practices. Furthermore, it mandates that all new contracts between PBMs and health carriers or plans must explicitly acknowledge the prohibition of spread pricing under the Act.

Section 8: Amends Neb. Rev. Stat. § 44-4611 to give the Director of the Department of Insurance the authority to suspend or revoke the license of a PBM.

Section 9: Repeals the original sections.

Explanation of amendments:
AM 1201 is a white copy amendment to LB 198 that strikes the original sections and substitutes the entirety of the bill with the following:

Section-by-Section Summary:

Section 1: Adds new sections 4 to 8 to the Pharmacy Benefit Manager Licensure and Regulation Act (Act).

Section 2: Amends Neb. Rev. Stat. § 44-4603 of the Act by adding nine (9) new definitions.

Section 3: Amends Neb. Rev. Stat. § 44-4610 by placing further restrictions on pharmacy benefit managers (PBMs) regarding specialty pharmacy networks. PBMs would be prohibited from applying stricter terms to unaffiliated specialty pharmacies than those used for their own affiliated pharmacies, and all contractual terms and conditions would need to comply with the Act. Furthermore, data reporting from specialty pharmacies would be limited to no more than quarterly, unless more frequent reporting is reasonably necessary for the PBM to meet legal data collection or reporting requirements. PBMs could only mandate specialty pharmacies to collect and submit data if it's essential for fulfilling legal reporting obligations, obtaining unique data required for its own contractual reporting duties under law, ensuring payment integrity or managing rebates, or if the data has already been submitted to the pharmacy's national accrediting organization. Beyond these restrictions, PBMs could establish contract terms to verify that specialty pharmacies have sufficient policies and metrics for quality patient care and procedures aligned with industry standards to prevent fraud, waste, or abuse.

Section 4: A new section that outlines requirements for specialty pharmacies that ship clinician-administered drugs and for PBMs or health carriers regarding the dispensing of those drugs. Specialty pharmacies shipping those drugs would need to comply with federal shipping laws (including United States Pharmacopeia General Chapter 800), provide 24/7 pharmacist or nurse access for provider or pharmacy questions, allow refill requests from patients and providers following utilization review procedures, and adhere to federal track and trace requirements, providing this information to the requesting provider if the drug needs compounding or manipulation. For drugs dispensed by a PBM or health carrier-selected specialty pharmacy, the requesting provider would need to give at least 5 business days' notice for delivery, and the specialty pharmacy would need to obtain a signature upon delivery to a health care provider. If delivery was not as specified, the patient would not be financially responsible if the drug could not be administered. These requirements would not apply when the specialty pharmacy and the administering health care provider have shared ownership. PBMs or health carriers requiring specialty pharmacy dispensing would need to have a process for providers or pharmacies to appeal and seek exceptions if drugs aren't delivered as specified or if a provider reasonably believes that a patient might be harmed without immediate access to a drug the provider already

has. Finally, PBMs or health carriers would be prohibited from: requiring direct shipment to patients for them to transport to a provider; refusing to authorize or reimburse providers for dispensing based on similar costs; refusing to authorize or reimburse for administering these drugs; penalizing providers for refusing to administer drugs from a PBM/carrier-selected specialty pharmacy (though providers refusing to source from these pharmacies must direct patients to the health carrier for coverage options); or requiring patients to use a PBM/carrier-selected specialty pharmacy if the patient's chosen participating provider can source and administer the drug at a substantially similar cost.

Section 5: A new section that outlines prohibitions and allowances for health benefit plans, health carriers, and PBMs regarding where covered individuals can obtain pharmacist services. A health benefit plan, health carrier, or PBM would be prohibited from: mandating the exclusive use of mail-order or affiliated pharmacies for payment or reimbursement; preventing individuals from choosing a network pharmacist or pharmacy; transferring prescriptions without the individual's request; using financial incentives that exclusively benefit their affiliated pharmacy; and automatically enrolling individuals in mail-order services (with a specific exception for maintenance medication). However, these entities would be allowed to: require the use of network specialty pharmacies; auto-enroll individuals in mail-order for maintenance medications after the first 90 days of a new medication (provided the individual could opt out at any time); inform individuals about lower-cost pharmacy options; and require the use of mail-order or affiliated pharmacies when other network pharmacies do not offer the service.

Section 6: A new section that addresses the rights and responsibilities of network pharmacies and pharmacists regarding dispensing drugs when reimbursement is below acquisition cost, and protects them from retaliation for such refusals. A network pharmacy or pharmacist would have the right to decline dispensing a drug if the reimbursement they would receive is less than what they paid to acquire it. If they do decline to provide the drug, they would be obligated to give the patient sufficient information on where the prescription could be filled or direct them to his or her plan sponsor for assistance. Furthermore, PBMs, pharmacy services administrative organizations, or anyone acting on their behalf would be prohibited from penalizing, removing from the network, or retaliating against a network pharmacy or pharmacist solely for refusing to dispense a drug under these circumstances.

Section 7: A new section relating to the ability of retail pharmacies to offer delivery services to covered persons. Contracts between retail pharmacies and PBMs or plan sponsors could not prohibit retail pharmacies from offering prescription drug delivery via mail or common carrier (at the covered person's request before delivery) or by its own employees or contractors. Retail pharmacies would not be obligated to re-request delivery for refills or renewals if the covered person has previously requested it and confirms that he or she still wants the drug. PBMs or plan sponsors could not remove a retail pharmacy from their network or force them to join a mail-order network solely for providing these delivery services, as long as the services comply with this section and the terms of their existing contract. Unless otherwise specified in the contract, retail pharmacies could not charge the plan sponsor or PBM for these delivery services. If a retail pharmacy does provide delivery, they must disclose any delivery fees to the covered person and inform the covered person that the plan sponsor or PBM might not reimburse these fees. Finally, the section defines a "retail pharmacy" as one that primarily dispenses drugs to individuals residing or receiving care nearby, typically through face-to-face interaction.

Section 8: A new section that prohibits the use of "spread pricing" (defined in Neb. Rev. Stat. § 44-4603) in contracts between PBMs and health benefit plans. A contract issued on or after January 1, 2026 shall not include spread pricing spread pricing unless such contract was an extension of a contract entered into prior to January 1, 2026, which included spread pricing. Furthermore, starting January 1, 2029, all contracts between PBMs and health benefit plans are prohibited from including spread pricing.

Section 9: Operative date section.

Section 10: Repealer clause.

Mike Jacobson, Chairperson