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LEGISLATIVE BILL 198

Approved by the Governor May 20, 2025

Introduced by Sorrentino, 39; Hallstrom, 1; Sanders, 45.

A BILL FOR AN ACT relating to the Pharmacy Benefit Manager Licensure and Regulation Act; amend sections 44-4601, 44-4603, and 44-4610, Revised Statutes Cumulative Supplement, 2024; to define terms; to change provisions relating to specialty pharmacies and clinician-administered drugs; to prohibit health benefit plans, health carriers, and pharmacy benefit managers from taking certain actions; to authorize a network pharmacy or network pharmacist to decline to provide a drug as prescribed; to change provisions relating to retail pharmacies; to prohibit spread pricing as prescribed; to harmonize provisions; to provide an operative date; and to repeal the original sections.

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

Section 1. Section 44-4601, Revised Statutes Cumulative Supplement, 2024, is amended to read:

44-4601 Sections 44-4601 to 44-4612 and sections 4 to 8 of this act shall be known and may be cited as the Pharmacy Benefit Manager Licensure and Regulation Act.

Sec. 2. Section 44-4603, Revised Statutes Cumulative Supplement, 2024, is amended to read:

44-4603 For purposes of the Pharmacy Benefit Manager Licensure and Regulation Act:

(1) Auditing entity means a pharmacy benefit manager or any person that represents a pharmacy benefit manager in conducting an audit for compliance with a contract between the pharmacy benefit manager and a pharmacy;

(2) Claims processing service means an administrative service performed in connection with the processing and adjudicating of a claim relating to a pharmacist service that includes:

(a) Receiving a payment for a pharmacist service; or

(b) Making a payment to a pharmacist or pharmacy for a pharmacist service;

(3) Clinician-administered drug means an outpatient prescription drug other than a vaccine that:

(a) Cannot reasonably be self-administered by the covered person to whom the drug is prescribed or by an individual assisting the covered person with self-administration; and

(b) Is typically administered:

(i) By a health care provider authorized to administer the drug, including when acting under a physician's delegation and supervision; and

(ii) In a physician's office, hospital outpatient infusion center, or other clinical setting;

(4) ~~(3)~~ Covered person means a member, policyholder, subscriber, enrollee, beneficiary, dependent, or other individual participating in a health benefit plan;

(5) ~~(4)~~ Director means the Director of Insurance;

(6) ~~(5)~~ Health benefit plan means a policy, contract, certificate, plan, or agreement entered into, offered, or issued by a health carrier or self-funded employee benefit plan to the extent not preempted by federal law to provide, deliver, arrange for, pay for, or reimburse any of the costs of a physical, mental, or behavioral health care service;

(7) ~~(6)~~ Health carrier has the same meaning as in section 44-1303;

(8) Maintenance medication means a drug prescribed for a chronic, long-term condition and taken on a regular, recurring basis;

(9) Network pharmacist means a pharmacist that has a contract, either directly or through a pharmacy services administrative organization, with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate;

(10) Network pharmacy means a pharmacy that has a contract, either directly or through a pharmacy services administrative organization, with a pharmacy benefit manager to provide covered drugs at a negotiated reimbursement rate;

(11) ~~(7)~~ Other prescription drug or device service means a service other than a claims processing service, provided directly or indirectly, whether in connection with or separate from a claims processing service, including, but not limited to:

(a) Negotiating a rebate, discount, or other financial incentive or arrangement with a drug company;

(b) Disbursing or distributing a rebate;

(c) Managing or participating in an incentive program or arrangement for a pharmacist service;

(d) Negotiating or entering into a contractual arrangement with a pharmacist or pharmacy;

(e) Developing and maintaining a formulary;

(f) Designing a prescription benefit program; or

(g) Advertising or promoting a service;

(12) Participating provider has the same meaning as in section 44-7103;

(13) ~~(8)~~ Pharmacist has the same meaning as in section 38-2832;

(14) ~~(9)~~ Pharmacist service means a product, good, or service or any combination thereof provided as a part of the practice of pharmacy;

(15) ~~(10)~~ Pharmacy has the same meaning as in section 71-425;

(16)(a) ~~(11)(a)~~ Pharmacy benefit manager means a person, business, or entity, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides a claims processing service or other prescription drug or device service for a health benefit plan to a covered person who is a resident of this state; and

(b) Pharmacy benefit manager does not include:

(i) A health care facility licensed in this state;

(ii) A health care professional licensed in this state;

(iii) A consultant who only provides advice as to the selection or performance of a pharmacy benefit manager; or

(iv) A health carrier to the extent that it performs any claims processing service or other prescription drug or device service exclusively for its enrollees; ~~and~~

(17) Pharmacy benefit manager affiliate means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by, or is under common ownership or control with a pharmacy benefit manager;

(18) Pharmacy services administrative organization means an entity that provides a contracted pharmacy with contracting administrative services relating to prescription drug benefits;

(19) ~~(12)~~ Plan sponsor has the same meaning as in section 44-2702; ~~.~~

(20) Specialty pharmacy means:

(a) A pharmacy that specializes in dispensing drugs for patients with rare or complex medical conditions;

(b) A pharmacy that specializes in prescription drugs that have specific storage or dispensing requirements; or

(c) A pharmacy that holds a specialty pharmacy accreditation from a nationally recognized independent accrediting organization; and

(21) Spread pricing means the method of pricing a drug in which the contracted price for a drug that a pharmacy benefit manager charges a health benefit plan differs from the amount the pharmacy benefit manager directly or indirectly pays the pharmacist or pharmacy for pharmacist services.

Sec. 3. Section 44-4610, Revised Statutes Cumulative Supplement, 2024, is amended to read:

44-4610 (1) A pharmacy benefit manager shall not exclude a Nebraska pharmacy from participation in the pharmacy benefit manager's specialty pharmacy network if:

(a) ~~(1)~~ The pharmacy holds a specialty pharmacy accreditation from a nationally recognized independent accrediting organization; and

(b) ~~(2)~~ The pharmacy is willing to accept the terms and conditions of the pharmacy benefit manager's agreement with the pharmacy benefit manager's specialty pharmacies.

(2) A pharmacy benefit manager shall not:

(a) Apply terms and conditions to an unaffiliated specialty pharmacy that are stricter than the terms and conditions required for any specialty pharmacy affiliated with the pharmacy benefit manager;

(b) Apply terms and conditions to specialty pharmacies that are inconsistent with the Pharmacy Benefit Manager Licensure and Regulation Act; or

(c) Require data reporting from specialty pharmacies more frequently than quarterly unless reasonably necessary for the pharmacy benefit manager to collect or report data obtained pursuant to subdivision (3)(a) or (b) of this section.

(3) A pharmacy benefit manager shall not impose reporting terms and conditions that require a specialty pharmacy to collect and remit data unless such terms and conditions are:

(a) Necessary for a pharmacy benefit manager to meet reporting obligations required by federal or state laws or regulations;

(b) Related to data (i) that may only be obtained from the specialty pharmacy and (ii) that a pharmacy benefit manager is contractually obligated to provide to another entity in order for that entity to meet reporting obligations required by federal or state laws or regulations;

(c) Necessary for purposes of payment integrity or rebate administration; or

(d) Submitted by the specialty pharmacy to the nationally recognized independent accrediting organization from which the specialty pharmacy holds an accreditation.

(4) In addition to other terms and conditions consistent with this section, a pharmacy benefit manager may impose contract terms and conditions that are reasonably necessary to demonstrate that the specialty pharmacy has sufficient:

(a) Policies and metrics related to providing quality and consistent care for patients using the pharmacy; and

(b) Policies and procedures consistent with industry standards to avoid instances of fraud, waste, or abuse.

Sec. 4. (1) A specialty pharmacy that ships a clinician-administered drug to a health care provider or pharmacy shall:

(a) Comply with all federal laws regulating the shipment of drugs, including, but not limited to, general chapter 800 of the United States

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(b) In response to questions from a health care provider or pharmacy, provide access to a pharmacist or nurse employed by the specialty pharmacy twenty-four hours per day, seven days per week;

(c) Allow a covered person and health care provider to request a refill of a clinician-administered drug on behalf of a covered person in accordance with the pharmacy benefit manager's or health carrier's utilization review procedures; and

(d) Adhere to the track and trace requirements, as described in the federal Drug Supply Chain Security Act, 21 U.S.C. 360eee et seq., for a clinician-administered drug that needs to be compounded or manipulated and, if requested by the health care provider or the provider's designee, provide the track and trace information to the health care provider or designee.

(2) For any clinician-administered drug dispensed by a specialty pharmacy selected by the pharmacy benefit manager or health carrier, the requesting health care provider or the provider's designee shall provide the requested date, approximate time, and place of delivery of a clinician-administered drug at least five business days before the date of delivery. The specialty pharmacy shall require a signature of the health care provider or the provider's designee upon receipt of the shipment when shipped to a health care provider. If any clinician-administered drug dispensed by a specialty pharmacy is not delivered as specified in this subsection, the covered person shall not be financially responsible if the clinician-administered drug is not able to be administered to the covered person.

(3) The requirements of subsections (1) and (2) of this section do not apply when the specialty pharmacy and the health care provider administering the clinician-administered drug have shared ownership.

(4) A pharmacy benefit manager or health carrier that requires dispensing of a clinician-administered drug through a specialty pharmacy shall establish and disclose a process which allows the health care provider or pharmacy to appeal and have exceptions to the use of a specialty pharmacy when:

(a) A drug is not delivered as specified in subsection (2) of this section; or

(b) An attending health care provider reasonably believes a covered person may experience harm without the immediate use of a clinician-administered drug that a health care provider or pharmacy has in stock.

(5) A pharmacy benefit manager or health carrier shall not:

(a) Require a specialty pharmacy to dispense a covered clinician-administered drug directly to a covered person with the intention that the covered person will transport the clinician-administered drug to a health care provider for administration;

(b) Refuse to authorize or reimburse a participating provider for dispensing a covered clinician-administered drug based on costs if the costs of the drug to the health benefit plan are substantially similar as compared to the costs of the drug if provided from a specialty pharmacy selected by the pharmacy benefit manager or health carrier;

(c) Refuse to authorize or reimburse a participating provider pursuant to the network agreement for the administration of covered clinician-administered drugs;

(d) Penalize or remove from the network a participating provider solely for refusing to administer a covered clinician-administered drug received from a specialty pharmacy selected by the pharmacy benefit manager or health carrier. If a participating provider refuses to source covered clinician-administered drugs from a specialty pharmacy selected by the pharmacy benefit manager or health carrier, the participating provider shall direct the covered person to contact the health carrier for coverage options; or

(e) Require a covered person to obtain a clinician-administered drug from a specialty pharmacy selected by the pharmacy benefit manager or health carrier if a participating provider of the covered person's choice sources the drug and provides for administration at substantially similar costs.

Sec. 5. (1) A health benefit plan, health carrier, or pharmacy benefit manager shall not:

(a) Require a covered person, as a condition of payment or reimbursement, to obtain pharmacist services exclusively through the mail-order pharmacy or pharmacy benefit manager affiliate;

(b) Prohibit or limit a covered person from selecting a network pharmacist or network pharmacy of the covered person's choice;

(c) Transfer a covered person's prescriptions from a network pharmacy to another pharmacy unless requested by the covered person;

(d) Use financial incentives, including, but not limited to, adjustments in cost-sharing obligations of a covered person, to the exclusive benefit of the pharmacy benefit manager affiliate pharmacy; or

(e) Except as provided in subdivision (2)(b) of this section, auto-enroll a covered person in mail-order pharmacist services.

(2) Nothing in this section shall be construed to prevent a health benefit plan, health carrier, or pharmacy benefit manager from:

(a) Requiring a covered person to use a network specialty pharmacy;

(b) Auto-enrolling a covered person in mail-order pharmacist services for a maintenance medication, provided that a covered person:

(i) Shall not be auto-enrolled for the first ninety days of a new maintenance medication; and

(ii) Shall have the ability to opt out of mail-order pharmacist services at any time;

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(c) Informing a covered person of an ability to obtain pharmacist services at a lower cost; or

(d) Requiring a covered person to obtain pharmacist services from a mail-order pharmacy or pharmacy benefit manager affiliate when such services are not otherwise available from another network pharmacy.

Sec. 6. (1) A network pharmacy or network pharmacist may decline to provide a drug if the pharmacy or pharmacist will be or is paid less than the acquisition cost for the drug.

(2) If a network pharmacy or network pharmacist declines to provide a drug as authorized in subsection (1) of this section, the pharmacy or pharmacist shall provide the covered person with adequate information as to where the prescription for the drug may be filled or shall refer the covered person to his or her plan sponsor.

(3) A pharmacy benefit manager, pharmacy services administrative organization, or any person acting on behalf of a pharmacy benefit manager or pharmacy services administrative organization shall not penalize, remove from the network, or otherwise retaliate against a network pharmacy or network pharmacist solely for declining to provide a drug as provided in subsection (1) of this section.

Sec. 7. (1) A contract between a retail pharmacy and a pharmacy benefit manager or plan sponsor shall not prohibit the retail pharmacy from offering the following as an ancillary service of the retail pharmacy:

(a) The delivery of a prescription drug by mail or common carrier to a covered person or his or her personal representative on request of the covered person or personal representative if the request is made before the drug is delivered; or

(b) The delivery of a prescription to a covered person or his or her personal representative by an employee or contractor of the retail pharmacy.

(2) Nothing in this section shall require a retail pharmacy to receive a request from a covered person or his or her personal representative for delivery of a drug by mail, common carrier, or an employee or contractor of the retail pharmacy when refilling or renewing prescription drug services for which a request was previously received, so long as the retail pharmacy has confirmed that the covered person wishes to receive the drug.

(3) A pharmacy benefit manager or plan sponsor shall not remove a retail pharmacy from its networks or require a retail pharmacy to join a mail-order pharmacy network for the sole reason of providing ancillary delivery services as long as the ancillary delivery services were provided in compliance with this section and with the terms and conditions of the retail pharmacy's contract with the pharmacy benefit manager or plan sponsor and its pharmacy services administrative organization, if applicable.

(4) Except as otherwise provided in a contract described in subsection (1) of this section, a retail pharmacy shall not charge a plan sponsor or pharmacy benefit manager for the delivery service described in subsection (1) of this section.

(5) If a retail pharmacy provides a delivery service described in subsection (1) of this section to a covered person, the retail pharmacy shall disclose both of the following to the covered person or his or her personal representative:

(a) Any fee charged to the covered person for the delivery of a prescription drug; and

(b) That the plan sponsor or pharmacy benefit manager may not reimburse the covered person for the fee described in subdivision (a) of this subsection.

(6) For purposes of this section, retail pharmacy means a pharmacy that dispenses prescription drugs to the public at retail primarily to individuals who reside in close proximity or who are receiving care from a provider in close proximity to the pharmacy, typically by face-to-face interaction with the individual or the individual's caregiver.

Sec. 8. (1) A contract between a pharmacy benefit manager and a health benefit plan that is issued on or after January 1, 2026, shall not contain spread pricing unless such contract is an extension of a contract entered into prior to January 1, 2026, which included spread pricing.

(2) Beginning January 1, 2029, no contract between a pharmacy benefit manager and a health benefit plan shall include spread pricing.

Sec. 9. This act becomes operative on January 1, 2026.

Sec. 10. Original sections 44-4601, 44-4603, and 44-4610, Revised Statutes Cumulative Supplement, 2024, are repealed.