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LEGISLATURE OF NEBRASKA

ONE HUNDRED EIGHTH LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 833

Introduced by Blood, 3.

Read first time January 03, 2024

Committee: Banking, Commerce and Insurance

A BILL FOR AN ACT relating to public health; to adopt the Prescription Drug Affordability Act.

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

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Section 1. Sections 1 to 16 of this act shall be known and may be cited as the Prescription Drug Affordability Act.

Sec. 2. (1) The Legislature finds that:

(a) Excessive costs for prescription drugs (i) negatively impacts the ability of Nebraskans to obtain prescription drugs and price increases that exceed reasonable levels endanger the health and safety of Nebraskans, (ii) threaten the economic well-being of Nebraskans and endanger their ability to pay for other necessary and essential goods and services, including housing, food, and utilities, (iii) contribute significantly to a dramatic and unsustainable rise in health care costs and health insurance premiums that threaten the financial health of Nebraskans and their ability to maintain their physical health, (iv) pose a threat to the health and safety of all Nebraskans and disproportionately harm people of color and Nebraskans with low incomes, and (v) contribute significantly to rising costs for health care provided to public employees, including employees of state, county, and local governments, school districts, and institutions of higher education, and to public retirees whose health care costs are funded by public programs, thereby threatening the ability of state and local governments to adequately fund those programs and other important services, such as public education and public safety;

(b) Lack of transparency in health insurance costs and wholesaler and pharmacy benefit manager discounts and margins prevent policymakers and the public from gaining a true understanding of the cost of prescription drugs; and

(c) Information relating to the cost of prescription drugs in Nebraska is necessary to provide accountability to the state and to all Nebraskans for prescription drug pricing.

(2) The Legislature therefore declares that it is imperative that Nebraska take measures to reduce excessive prescription drug costs for Nebraskans who cannot afford prescription drugs and create a prescription

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drug affordability board with the authority to review prescription drug costs and protect Nebraska residents and entities who purchase or reimburse for prescription drugs from the excessive costs of prescription drugs, including, but not limited to, state and local governments, contractors and vendors, commercial health plans, providers, and pharmacies.

Sec. 3. For purposes of the Prescription Drug Affordability Act:

(1) Advisory council means the Nebraska Prescription Drug Affordability Advisory Council created in section 11 of this act;

(2) Affordability review means an affordability review of a prescription drug performed by the board pursuant to section 5 of this act;

(3) Authorized generic drug has the same meaning as set forth in 42 C.F.R. 447.502;

(4) Biological product has the same meaning as set forth in 42 U.S.C. 262(i)(1);

(5) Biosimilar drug means a prescription drug produced or distributed in accordance with a biological product license issued pursuant to 42 U.S.C. 262(k)(3);

(6) Board means the Nebraska Prescription Drug Affordability Review Board created in section 4 of this act;

(7) Brand name drug means a prescription drug produced or distributed in accordance with an original new drug application approved pursuant to 21 U.S.C. 355 and does not include an authorized generic drug;

(8) Carrier means any entity that provides health coverage in this state, including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws of Nebraska;

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(9) Conflict of interest means an association, including a financial or personal association, that has the potential to bias or appear to bias an individual's decisions in matters related to the board or the advisory council or the conduct of the activities of the board or the advisory council. Conflict of interest includes any instance in which a board member, an advisory council member, or a staff member or a contractor of the Department of Health and Human Services, on behalf of the board, or an immediate family member of a board member, an advisory council member, or a staff member or a contractor of the department, on behalf of the board, has received or could receive a financial benefit (a) of any amount derived from the results or findings of a study or determination reached by or for the board or (b) from an individual that owns or manufactures a prescription drug service or item that is being or will be studied by the board;

(10) Department means the Division of Public Health of the Department of Health and Human Services;

(11) Financial benefit means honoraria, fees, stock, or any other form of compensation, including increases to the value of existing stock holdings;

(12) Generic drug means (a) a prescription drug marketed or distributed in accordance with an abbreviated new drug application approved pursuant to 21 U.S.C. 355(j), (b) an authorized generic drug, or (c) a prescription drug introduced for retail sale before 1962 that was not originally marketed under a new drug application;

(13) Health benefit plan means any hospital or medical expense policy or certificate, hospital or medical service corporation contract, or health maintenance organization subscriber contract or any other similar health contract available for use, offered, or sold in Nebraska. Health benefit plan does not include (a) accident only, (b) credit, (c) dental, (d) vision, (e) medicare supplement, (f) benefits for long-term care, home health care, community-based care, or any combination thereof,

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(g) disability income insurance, (h) liability insurance including general liability insurance and automobile liability insurance, (i) coverage for onsite medical clinics, (j) coverage issued as a supplement to liability insurance, workers' compensation, or similar insurance, (k) automobile medical payment insurance, or (l) specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates;

(14)(a) Large employer means any person, firm, corporation, or association that (i) is actively engaged in business, (ii) employed an average of more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in subdivision (c) of this subdivision, and (iii) was not formed primarily for the purpose of purchasing insurance.

(b) For purposes of determining whether an employer is a large employer, the number of eligible employees is calculated using the method set forth in 26 U.S.C. 4980H(c)(2)(E).

(c) In the case of an employer not in existence throughout the preceding calendar quarter, the determination of whether the employer is a large employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year;

(15) Manufacturer means a person that (a) engages in the manufacture of a prescription drug sold to purchasers in this state or (b) enters into a lease or other contractual agreement with a manufacturer to market and distribute a prescription drug under the person's own name and sets or changes the wholesale acquisition cost of the prescription drug in this state;

(16) Optional participating plan means a self-funded health benefit plan offered in Nebraska that elects to subject its purchases of, or payer reimbursements for, prescription drugs for its members to the

requirements of section 9 of this act;

(17) Practitioner means a person licensed in Nebraska to prescribe any drug or device;

(18) Prescription drug means a drug that is only intended for human use that (a) is required by any applicable federal or state law to be dispensed only pursuant to an order, (b) is restricted by any applicable federal or state law to use by practitioners only, or (c) prior to being dispensed or delivered, is required under federal law to be labeled with one of the following statements: (i) "Rx only"; or (ii) "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian";

(19) Pricing information means information about the price of a prescription drug, including information that explains or helps explain how the price was determined;

(20)(a) Small employer means any person, firm, corporation, partnership, or association that (i) is actively engaged in business, (ii) has employed an average of at least one but not more than one hundred eligible employees on business days during the immediately preceding calendar year, except as provided in subdivision (d) of this subdivision, and (iii) was not formed primarily for the purpose of purchasing insurance.

(b) For purposes of determining whether an employer is a small employer, the number of eligible employees is calculated using the method set forth in 26 U.S.C. 4980H(c)(2)(E).

(c) In order to be classified as a small employer with more than one employee when only one employee enrolls in the small employer's health benefit plan, the small employer shall submit to the small employer carrier the two most recent quarterly employment and tax statements substantiating that the employer had two or more eligible employees. Such small employer group shall also meet the participation requirements of the small employer carrier.

(d) In the case of an employer that was not in existence throughout the preceding calendar quarter, the determination of whether the employer is a small employer is based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(e) The following employers are single employers for purposes of determining the number of employees: (i) A person or entity that is a single employer pursuant to 26 U.S.C. 414(b), (c), (m), or (o); and (ii) an employer and any predecessor employer;

(21) State entity means any agency of state government that purchases or reimburses payers for prescription drugs on behalf of the state for a person whose health care is paid for by the state, including any agent, vendor, contractor, or other party acting on behalf of the state;

(22) Upper payment limit means the maximum amount that may be paid or billed for a prescription drug dispensed or distributed in Nebraska in any financial transaction concerning the purchase of, or reimbursement for, a prescription drug;

(23) Wholesale acquisition cost has the same meaning as set forth in 42 U.S.C. 1395w-3a(c)(6)(B); and

(24) Wholesaler means a person engaged in the wholesale distribution of prescription drugs to persons, other than consumers, that are authorized by law to possess prescription drugs.

Sec. 4. (1) The Nebraska Prescription Drug Affordability Review Board is created in the Division of Public Health of the Department of Health and Human Services.

(2)(a) The board consists of five members, who shall each have an advanced degree and experience or expertise in health care economics or clinical medicine.

(b) The Governor shall appoint each board member, subject to confirmation by a majority of members of the Legislature.

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(c) The term of office of each board member is three years, except that, as to the terms of the members who are first appointed to the board, two such members shall serve three-year initial terms, two such members shall serve two-year initial terms, and one such member shall serve a one-year initial term, to be determined by the Governor.

(d) The Governor shall designate one member of the board to serve as the chairperson. A majority of the board constitutes a quorum. The concurrence of a majority of the board in any matter within its powers and duties is required for any determination made by the board.

(3)(a) An individual who is being considered for appointment to the board shall disclose any conflict of interest. When appointing a member of the board, the Governor shall consider any conflict of interest disclosed by the prospective member.

(b) A board member shall not be an employee, board member, or consultant of: (i) A manufacturer or a trade association of manufacturers; (ii) a carrier or a trade association of carriers; or (iii) a pharmacy benefit manager or a trade association of pharmacy benefit managers.

(c) Board members, staff members, and contractors of the department, on behalf of the board, shall recuse themselves from any board activity or vote in any case in which they have a conflict of interest.

(d) On and after January 1, 2025, the department shall maintain a page on its public website for the board to use for its purposes. The board shall publish on the website each conflict of interest that is disclosed to the board pursuant to subdivision (3)(c) of this section and section 11 of this act.

(e) Board members, staff members, contractors of the department, on behalf of the board, and immediate family members of board members, staff members, or contractors shall not accept a financial benefit or gifts, bequests, or donations of services or property that suggest a conflict of interest or have the appearance of creating bias in the work of the

board.

Sec. 5. (1) To protect Nebraska consumers from excessive prescription drug costs, the board shall:

(a) Collect and evaluate information concerning the cost of prescription drugs sold to Nebraska consumers, as described in section 7 of this act;

(b) Perform affordability reviews of prescription drugs, as described in section 8 of this act;

(c) Establish upper payment limits for prescription drugs, as described in section 9 of this act; and

(d) Make policy recommendations to the Legislature to improve the affordability of prescription drugs for Nebraska consumers, as described in subdivision (1)(h) of section 16 of this act.

(2) The board may establish ad hoc work groups to consider matters related to the work of the board pursuant to the Prescription Drug Affordability Act. Ad hoc work groups may include members of the public.

(3) The department, on behalf of the board, may enter into a contract with a qualified independent third party for any service necessary to carry out the powers and duties of the board. A third party with which the department contracts pursuant to this subsection, including any of the third party's directors, officers, employees, contractors, or agents, shall not release or publish any information that the third party acquires pursuant to its performance under the contract. Any third party with which the department contracts pursuant to this subsection shall disclose any conflict of interest to the board.

(4) In carrying out its duties on behalf of the board, the department shall be exempt from the state contracting requirements provided in sections 73-501 to 73-510.

(5) The department may adopt and promulgate rules and regulations to carry out the Prescription Drug Affordability Act.

(6) The department, on behalf of the board, may seek, accept, and

expend gifts, grants, and donations from private or public sources for the purposes of the act, except that the department shall not accept any gift, grant, or donation that creates a conflict of interest or the appearance of any conflict of interest for any board member.

Sec. 6. (1) The board shall hold its first meeting within six weeks after all board members are appointed and shall meet at least every six weeks thereafter to review prescription drugs, except that the chairperson may cancel or postpone a meeting if the board has no prescription drugs to review or for good cause.

(2) The board is a public body for purposes of the Open Meetings Act, and the board's meetings and the meetings of ad hoc work groups are public meetings.

(3) The board shall meet in executive session to discuss proprietary information. The board and any board members, officers, directors, employees, contractors, and agents shall not disclose or otherwise make available to the public any materials or information containing trade secret, confidential, or proprietary data that is not otherwise available to the public. Electronic recordings of such executive sessions are not permitted if they would result in the disclosure of any materials or information containing trade secret, confidential, or proprietary data, and in no case shall minutes from such executive sessions disclose or include materials or information containing trade secret, confidential, or proprietary data. The board shall not take any of the following actions while meeting in executive session:

(a) Deliberations concerning whether to subject a prescription drug to an affordability review as described in section 8 of this act;

(b) Votes concerning whether to establish an upper payment limit on a prescription drug; or

(c) Any final decision of the board.

Sec. 7. (1) Beginning January 1, 2025, for all prescription drugs dispensed at a pharmacy in this state and paid for by a carrier pursuant

to a health benefit plan during the immediately preceding calendar year, including brand name drugs, authorized generic drugs, biological products, and biosimilar drugs, each carrier and each pharmacy benefit management firm acting on behalf of a carrier shall report to the department the following information:

(a) The top fifteen prescription drugs for which the carrier paid by volume, calculated by unit;

(b) The fifteen costliest prescription drugs for which the carrier paid, as determined by total annual plan spending;

(c) The fifteen prescription drugs paid for by the carrier that accounted for the highest increase in total annual plan spending when compared with the total annual plan spending for the same prescription drugs in the year immediately preceding the year for which the information is reported;

(d) The fifteen prescription drugs that caused the greatest increases in the carrier's premiums;

(e) The fifteen prescription drugs for which the carrier paid most frequently and for which the carrier received a rebate from manufacturers;

(f) The fifteen prescription drugs for which the carrier received the highest rebates, as determined by percentages of the price of the prescription drug;

(g) The fifteen prescription drugs for which the carrier received the largest rebates;

(h) The total spending for each of the following categories of prescription drugs: (i) Brand name drugs purchased from retail pharmacies; (ii) authorized generic drugs purchased from retail pharmacies; (iii) brand name drugs purchased from mail-order pharmacies; (iv) authorized generic drugs purchased from mail-order pharmacies; (v) prescription drugs dispensed by a practitioner; (vi) prescription drugs administered in an inpatient hospital setting; and (vii) prescription

drugs administered in an outpatient hospital setting; and

(i) The total spending for the prescription drugs described in subdivision (h) of this subsection paid for by a carrier pursuant to a health benefit plan during the immediately preceding calendar year for each of the following market sectors:

(i) Individual;

(ii) Small employer; and

(iii) Large employer.

(2) The department shall provide to the Department of Insurance the information reported by carriers and pharmacy benefit management firms pursuant to subsection (1) of this section.

(3)(a) Except as provided in subdivision (3)(b) of this section, the Department of Insurance shall: (i) Post the information reported by carriers and pharmacy benefit management firms pursuant to this section on the Department of Insurance's website; and (ii) provide the information reported by carriers and pharmacy benefit management firms pursuant to this section to the board, in a form and manner prescribed by the board.

(b) If a carrier or pharmacy benefit management firm claims that information submitted pursuant to this section is confidential or proprietary, the Department of Insurance shall review the information and redact specific items that the carrier or pharmacy benefit management firm demonstrates to be confidential or proprietary. The Department of Insurance shall not disclose redacted items to any person, except (i) as may be required by sections 84-712 to 84-712.09 and (ii) to employees of the Department of Insurance, as necessary.

(4) The requirement in this section to report information relating to the cost of prescription drugs is intended to create transparency in prescription drug pricing and does not:

(a) Prohibit a manufacturer of a prescription drug from making pricing decisions about its prescription drugs; or

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(b) Prohibit purchasers, both public and private, or pharmacy benefit management firms from negotiating discounts and rebates consistent with existing state and federal law.

Sec. 8. (1) The board may conduct affordability reviews of prescription drugs in accordance with this section. The board shall identify, for purposes of determining whether to conduct an affordability review:

(a) Any prescription drug that has:

(i) A wholesale acquisition cost of three thousand dollars or more;

(ii) An increase of three hundred dollars or more above the wholesale acquisition cost for the prescription drug in the preceding twelve months;

(iii) An increase of two hundred percent or more above the wholesale acquisition cost for the prescription drug in the preceding twelve months; or

(iv) A current wholesale acquisition cost for an average course of treatment per person per year of thirty thousand dollars or more;

(b) Any biosimilar drug that has an initial wholesale acquisition cost that is not at least fifteen percent lower than the wholesale acquisition cost of the corresponding biological product; and

(c) A generic drug:

(i) That, as adjusted annually for inflation, has a wholesale acquisition cost of one hundred dollars or more for:

(A) A thirty-day supply based on the recommended dosage approved for labeling by the federal Food and Drug Administration;

(B) A supply that lasts less than thirty days based on the recommended dosage approved for labeling by the federal Food and Drug Administration; or

(C) One dose of the generic drug if the labeling approved by the federal Food and Drug Administration does not recommend a finite dosage; and

(ii) For which the wholesale acquisition cost increased by two hundred percent or more during the immediately preceding twelve months, as determined by comparing the current wholesale acquisition cost to the average wholesale acquisition cost reported during the immediately preceding twelve months.

(2) After identifying prescription drugs as described in subsection (1) of this section, the board shall determine whether to conduct an affordability review for an identified prescription drug by:

(a) Evaluating the class of the prescription drug and whether any therapeutically equivalent prescription drugs are available for sale;

(b) Evaluating aggregated data;

(c) Seeking and considering input from the advisory council about the prescription drug; and

(d) Considering the average patient's out-of-pocket cost for the prescription drug.

(3) If the board conducts an affordability review of a prescription drug, the affordability review shall determine whether use of the prescription drug consistent with the labeling approved for the prescription drug by the federal Food and Drug Administration or with standard medical practice is unaffordable for Nebraska consumers.

(4) In performing an affordability review, to the extent practicable, the board shall consider:

(a) The wholesale acquisition cost of the prescription drug;

(b) The cost and availability of therapeutic alternatives to the prescription drug in the state;

(c) The effect of the price on Nebraska consumers' access to the prescription drug;

(d) The relative financial effects on health, medical, or social services costs, as the effects can be quantified and compared to baseline effects of existing therapeutic alternatives to the prescription drug;

(e) The patient copayment or other cost sharing that is associated

with the prescription drug and typically required pursuant to health benefit plans issued by carriers in the state;

(f) The impact on safety net providers if the prescription drug is available through the federal Public Health Service Act, 42 U.S.C. 256b;

(g) Orphan drug status;

(h) Input from (i) patients and caregivers affected by the condition or disease that is treated by the prescription drug that is under review by the board and (ii) individuals who possess scientific or medical training with respect to a condition or disease treated by the prescription drug that is under review by the board;

(i) Any other information that a manufacturer, carrier, pharmacy benefit management firm, or other entity chooses to provide; and

(j) Any other factors as determined by the board.

(5) Trade secret, confidential, or proprietary information obtained by the board pursuant to this section may be accessed only by board members and staff or by a qualified independent third party that has contracted with the department pursuant to section 5 of this act and is subject to a nondisclosure agreement prohibiting disclosure of such information. Any person with access to such information shall protect the information from direct or indirect publication or release to any person.

(6) In performing an affordability review of a prescription drug, the board may consider any documents and information relating to the manufacturer's selection of the introductory price or price increase of the prescription drug, including documents and information relating to:

(a) Life-cycle management;

(b) The average cost of the prescription drug in the state;

(c) Market competition and context;

(d) Projected revenue;

(e) The estimated cost-effectiveness of the prescription drug; and

(f) Off-label usage of the prescription drug.

(7)(a) To the extent practicable, the board may access pricing

information for prescription drugs by:

(i) Accessing publicly available pricing information from a state to which manufacturers report pricing information;

(ii) Accessing available pricing information from the department and from state entities; and

(iii) Accessing information that is available from other countries.

(b) To the extent that there is no publicly available information with which to conduct an affordability review, the board may request that a manufacturer, carrier, or pharmacy benefit management firm provide pricing information for any prescription drug identified pursuant to subsection (1) of this section. The failure of an entity to provide pricing information to the board for an affordability review does not affect the authority of the board to conduct the affordability review.

(8) The board shall issue a report summarizing the data that the board considered in making the board's determination as to whether a prescription drug is unaffordable to the extent permitted by section 6 of this act. The board shall make the report available on its website.

Sec. 9. (1)(a) The board may establish an upper payment limit for any prescription drug for which the board has performed an affordability review pursuant to section 8 of this act and determined that the use of the prescription drug is unaffordable for Nebraska consumers, except that:

(i) The board may not establish an upper payment limit for more than twelve prescription drugs in each calendar year for three years beginning January 1, 2025, unless the board determines that there is a need to establish upper payment limits for more than twelve prescription drugs, in which case the board may establish an upper payment limit for up to eighteen prescription drugs so long as the board has sufficient staff support to do so; and

(ii) For each prescription drug for which the board establishes an upper payment limit, the board may include multiple national drug codes,

as described in 21 C.F.R. 207.33, that are indicated for the prescription drug.

(b) The failure of an entity to provide information to the board pursuant to subdivision (7)(b) of section 8 of this act does not affect the authority of the board to establish an upper payment limit for a prescription drug.

(2) The board shall determine the methodology for establishing an upper payment limit for a prescription drug to protect consumers from the excessive cost of prescription drugs and ensure they can access prescription drugs necessary for their health. The methodology shall consider:

(a) The cost of administering or dispensing the prescription drug;

(b) The cost of distributing the prescription drug to consumers;

(c) The status of the prescription drug on the drug shortage list published by the drug shortage program within the federal Food and Drug Administration; and

(d) Other relevant costs related to the prescription drug.

(3) The methodology determined by the board pursuant to subsection (2) of this section:

(a) Shall not consider research or methods that employ a dollars-per-quality adjusted life year, or similar measure, that discounts the value of a life because of an individual's disability or age; and

(b) Shall authorize a pharmacy licensed by the state to charge reasonable fees, to be paid by the providing health benefit plan of the consumer, for dispensing or delivering a prescription drug for which the board has established an upper payment limit.

(4) An upper payment limit applies to all purchases of, and payer reimbursements for, a prescription drug that is dispensed or administered to individuals in the state in person, by mail, or by other means and for which an upper payment limit is established. The board shall provide an effective date for any upper payment limit established by the board,

which shall be at least six months after the establishment of the upper payment limit. An upper payment limit shall apply only to purchases, contracts, and plans that are issued on, or renewed after, the effective date.

(5) The board shall notify consumers of any decision to establish an upper payment limit pursuant to this section in a manner determined by the board.

(6) Any information submitted to the board in accordance with this section or section 7 or 8 of this act is subject to public inspection only to the extent allowed under sections 84-712 to 84-712.09, and in no case shall trade secret, confidential, or proprietary information be disclosed to any person who is not authorized to access such information pursuant to section 8 of this act.

(7) For any upper payment limit established by the board pursuant to this section, the board shall:

(a) Inquire of manufacturers of the prescription drug as to whether each such manufacturer is able to make the prescription drug available for sale in the state and request the rationale for the manufacturer's response; and

(b) Submit annually to the Health and Human Services Committee of the Legislature the response of each manufacturer to the inquiry described in subdivision (7)(a) of this section.

Sec. 10. (1) The following board functions are not final agency actions subject to administrative review under the Administrative Procedure Act:

(a) Identification of eligible prescription drugs pursuant to subsection (1) of section 8 of this act;

(b) Selection of a prescription drug pursuant to subsection (2) of section 8 of this act; and

(c) Determination that a prescription drug is unaffordable pursuant to subsection (3) of section 8 of this act.

(2) The establishment of an upper payment limit by the board is a final agency action subject to administrative review under the Administrative Procedure Act. A party seeking administrative review of an upper payment limit may seek review of whether the prescription drug satisfies the necessary criteria in section 8 of this act to be eligible for an upper payment limit.

Sec. 11. (1)(a) The Nebraska Prescription Drug Affordability Advisory Council is created in the department to provide stakeholder input to the board regarding the affordability of prescription drugs. The advisory council consists of fourteen members appointed by the board as follows:

(i) Two members who are health care consumers or who represent health care consumers;

(ii) One member representing a statewide health care consumer advocacy organization;

(iii) One member representing health care consumers who are living with chronic diseases;

(iv) One member representing a labor union;

(v) One member representing employers;

(vi) One member representing carriers;

(vii) One member representing pharmacy benefit management firms;

(viii) One member representing health care professionals with prescribing authority;

(ix) One member who is employed by an organization that performs research concerning prescription drugs, including research concerning pricing information;

(x) One member representing manufacturers of brand name drugs;

(xi) One member representing manufacturers of generic drugs;

(xii) One member representing pharmacists; and

(xiii) One member representing wholesalers.

(b) To the extent possible, the board shall appoint council members

who have experience serving underserved communities and reflect the diversity of the state with regard to race, ethnicity, immigration status, income, wealth, disability, age, gender identity, and geography.

(c) The initial members of the advisory council shall be appointed by January 1, 2025.

(2) Each member of the advisory council shall possess knowledge of at least one of the following subject matters:

(a) The pharmaceutical business model;

(b) Supply chain business models;

(c) The practice of medicine or clinical training;

(d) Health care consumer or patient perspectives;

(e) Health care cost trends and drivers;

(f) Clinical and health services research; or

(g) The state's health care marketplace.

(3) The term of each member of the advisory council is three years.

(4) The chairperson of the board shall designate one member of the advisory council to serve as chairperson of the advisory council.

(5)(a) An individual who is being considered for appointment to the advisory council shall disclose any conflict of interest to the board in a form and manner prescribed by the board. When appointing a member of the advisory council, the board shall consider any conflict of interest disclosed by the prospective member.

(b) The chairperson of the advisory council shall report to the board any conflict of interest that is disclosed to the advisory council. The board shall include information concerning such disclosures on its public website pursuant to subdivision (3)(d) of section 4 of this act.

(6) The advisory council shall meet at least once every three months.

(7) The advisory council shall conduct all of its meetings in public except that it may meet privately in groups of three or fewer members to gather and understand data or to establish, organize, and plan for the

business of the advisory council.

Sec. 12. (1) Any savings generated for a health benefit plan that is attributable to the establishment of an upper payment limit established by the board pursuant to section 9 of this act shall be used by the carrier that issues the health benefit plan to reduce costs to consumers, prioritizing the reduction of out-of-pocket costs for prescription drugs.

(2) On or before March 15, 2026, and on or before March 15 of each year thereafter, each state entity and each carrier that issues a health benefit plan or optional participating plan shall submit to the board a report describing the savings achieved during the preceding plan year for each prescription drug for which the board established an upper payment limit during the preceding year and how those savings were used to satisfy the requirement described in subsection (1) of this section.

(3) On or before November 1, 2025, the board shall establish a formula for calculating savings for the purpose of complying with subsection (1) of this section and shall publish such formula on its website.

Sec. 13. (1) On and after January 1, 2026, it is unlawful for any person to purchase or reimburse a payer for a prescription drug for which the board has established an upper payment limit pursuant to section 9 of this act at an amount that exceeds the upper payment limit established by the board for that prescription drug, regardless of whether the prescription drug is dispensed or distributed in person, by mail, or by other means.

(2) On and after January 1, 2026, each state entity, carrier, and optional participating plan shall require compliance with an upper payment limit established by the board.

(3) The Attorney General is authorized to enforce the Prescription Drug Affordability Act on behalf of any state entity or any consumer of prescription drugs.

(4) As used in this section, a person is not an individual who acquires a prescription drug for the individual's own use or for a family member's use.

(5) A carrier or state agency that is required by state or federal law to purchase or reimburse a payer for a prescription drug for which the board has established an upper payment limit pursuant to section 9 of this act is not subject to an enforcement action for a violation of subsection (1) or (2) of this section for such prescription drug.

Sec. 14. (1) Any manufacturer that intends to withdraw a prescription drug from sale or distribution for which the board has established an upper payment limit pursuant to section 9 of this act shall provide a notice of withdrawal in writing at least one hundred eighty days before the withdrawal to:

(a) The Department of Insurance;

(b) The Attorney General; and

(c) Each entity in the state with which the manufacturer has contracted for the sale or distribution of the prescription drug.

(2) The board shall notify consumers of the intent of any manufacturer to withdraw a prescription drug from sale or distribution within the state, as described in subsection (1) of this section, in a manner determined by the board.

(3) The Department of Insurance may require a manufacturer to pay a penalty not to exceed five hundred thousand dollars if it determines that the manufacturer failed to provide the notice required by subsection (1) of this section before withdrawing a prescription drug from sale or distribution for which the board has established an upper payment limit pursuant to section 9 of this act.

Sec. 15. An optional participating plan that elects to subject its purchases of, or payer reimbursements for, prescription drugs in Nebraska to the requirements of the Prescription Drug Affordability Act shall notify the Department of Insurance in writing within thirty days after

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such election.

Sec. 16. (1) On or before July 1, 2026, and on or before July 1 of each year thereafter, the board shall submit a report to the Governor and the Health and Human Services Committee of the Legislature summarizing the work of the board during the preceding calendar year. The report shall include:

(a) Publicly available data concerning price trends for prescription drugs;

(b) The number of prescription drugs that were subjected to an affordability review by the board pursuant to section 8 of this act, including the results of each affordability review;

(c) A list of each prescription drug for which the board established an upper payment limit pursuant to section 9 of this act, including the amount of the upper payment limit;

(d) The impact of any upper payment limits established by the board pursuant to section 9 of this act on health care providers, pharmacies, and patients' ability to access any prescription drug;

(e) A summary of the administrative reviews of board decisions, including the outcome of each review;

(f) A description of each conflict of interest that was disclosed to the board during the preceding year;

(g) A description of any violations of any of the provisions of the Prescription Drug Affordability Act, including any enforcement action taken in response to any such violation; and

(h) Any recommendations the board has for the Legislature concerning policy changes to increase the affordability of prescription drugs and reduce the effects of excess costs on consumers and commercial health insurance premiums in the state.

(2) The board shall publish the report described in subsection (1) of this section on its website pursuant to subdivision (3)(d) of section 4 of this act.

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(3) The chairperson of the board shall present to the Health and Human Services Committee of the Legislature, information concerning each prescription drug for which the board established an upper payment limit during the preceding calendar year. The chairperson shall summarize for the committee members:

(a) The affordability review of each prescription drug, including the results of the board's considerations as described in subsection (4) of section 8 of this act and, if applicable, subsection (6) of section 8 of this act; and

(b) The establishment of the upper payment limit, including a summary of the methodology used to establish the upper payment limit.