A BILL FOR AN ACT relating to pharmacy; to adopt the Pharmacy Benefit
Fairness and Transparency Act.

Be it enacted by the people of the State of Nebraska,
Section 1. Sections 1 to 15 of this act shall be known and may be
cited as the Pharmacy Benefit Fairness and Transparency Act.

Sec. 2. For purposes of the Pharmacy Benefit Fairness and
Transparency Act:

(1) Clean claim means a claim which is received by a pharmacy
benefit manager for adjudication and which requires no further
information, adjustment, or alteration by the contracted pharmacy or the
covered individual in order to be processed and paid by the pharmacy
benefit manager. A claim is a clean claim if it has no defect or
impropriety, including any lack of substantiating documentation, or no
particular circumstance requiring special treatment that prevents timely
payment from being made on the claim. A clean claim includes a
resubmitted claim with previously identified deficiencies corrected;

(2) Contracted pharmacy means a pharmacy located in this state that
participates either in the network of a pharmacy benefit manager or in a
health care or pharmacy benefits management plan through a direct
contract or through a contract with a pharmacy services organization, a
group purchasing organization, or another contracting agent;

(3)(a) Covered entity means a nonprofit hospital or medical services
corporation, health insurer, managed care company, or health maintenance
organization; a health program administered by the state in the capacity
of provider of health insurance coverage; or an employer, labor union, or
other group of persons organized in the state that provides health
insurance coverage.

(b) Covered entity does not include a self-funded health insurance
coverage plan that is exempt from state regulation pursuant to the
federal Employee Retirement Income Security Act of 1974, a plan issued
for health insurance coverage for federal employees, a health plan that
provides insurance coverage only for accidental injury, specified
disease, hospital indemnity, medicare supplemental, disability income, or
long-term care, or any other limited benefit health insurance policy or
contract;

(4) Covered individual means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a covered entity who is provided health insurance coverage by the covered entity and includes a dependent or other person provided health insurance coverage through a policy, contract, or plan for a covered individual;

(5) Day means a calendar day unless otherwise defined or limited;

(6) Department means the Department of Insurance;

(7) Director means the Director of Insurance;

(8) Generic drug means a chemically equivalent copy of a brand-name drug with an expired patent;

(9)(a) Insurer means any person providing life insurance, sickness and accident insurance, workers' compensation insurance, or annuities in this state.

(b) Insurer includes an authorized insurance company, a prepaid hospital or medical care plan, a managed care plan, a health maintenance organization, any other person providing a plan of insurance subject to state insurance regulation, and an employer who is approved by the Nebraska Workers' Compensation Court as a self-covered entity.

(c) Insurer does not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the federal Employee Retirement Income Security Act of 1974;

(10) Pharmacist has the same meaning as in section 38-2832;

(11) Pharmacy has the same meaning as in section 71-425;

(12)(a) Pharmacy benefit manager means a person or entity performing pharmacy benefits management services for a covered entity and includes a person acting on behalf of a pharmacy benefit manager pursuant to a contractual or employment relationship.

(b) Pharmacy benefit manager does not include (i) a health insurer licensed in the state if the health insurer or its subsidiary is
providing pharmacy benefits management services exclusively to its own
insureds or (ii) a public self-funded pool or a private single employer
self-funded plan that provides pharmacy benefits management services
directly to its beneficiaries;

(13) Pharmacy benefits management means the administration or
management of prescription drug benefits provided by a covered entity
under the terms and conditions of the contract between the pharmacy
benefit manager and the covered entity;

(14) Prescription has the same meaning as in section 38-2840;

(15) Prescription drug means a prescription drug or device or legend
drug or device as defined in section 38-2841; and

(16) Reimbursement amount means the amount that the contracted
pharmacy will receive for prescription drugs, including, but not limited
to, single-source and multiple-source prescription drugs and specialty
drugs.

Sec. 3. (1) A pharmacy benefit manager doing business in this state
shall obtain a certificate of authority as a third-party administrator
under the Third-Party Administrator Act and shall be subject to both the
Third-Party Administrator Act and the Pharmacy Benefit Fairness and
Transparency Act.

(2) In addition to the fees required under the Third-Party
Administrator Act, a pharmacy benefit manager shall pay to the director a
certification fee established by the director. The certification fee
shall be set to allow the oversight activities required under the
Pharmacy Benefit Fairness and Transparency Act to be self-supporting, but
such fee shall not exceed five thousand dollars.

(3) The director shall enforce the Pharmacy Benefit Fairness and
Transparency Act. After notice and hearing, the director may suspend or
revoke a pharmacy benefit manager’s certificate of authority as a third-
party administrator upon finding that the pharmacy benefit manager
violated any of the requirements of the Third-Party Administrator Act or
the Pharmacy Benefit Fairness and Transparency Act.

(4) In addition to other remedies and penalties available under the law of this state, each violation of the Pharmacy Benefit Fairness and Transparency Act shall be an unfair trade practice in the business of insurance subject to the Unfair Insurance Trade Practices Act.

(5) The director may examine the financial condition, affairs, and management of any pharmacy benefit manager pursuant to the Insurers Examination Act.

Sec. 4. A pharmacy benefit manager shall exercise good faith and fair dealing in performing its duties under a contract with a covered entity or a contracted pharmacy.

Sec. 5. If a covered individual or pharmacist receives incorrect, misleading, or inaccurate information from a pharmacy benefit manager or a vendor or agent of the pharmacy benefit manager, the covered individual or pharmacist may contact the department and request corrective actions or sanctions from the director against the pharmacy benefit manager or the vendor or agent. The cost of the corrective actions or sanctions shall be the responsibility of the pharmacy benefit manager.

Sec. 6. (1) A pharmacy benefit manager shall not mandate to contracted pharmacies basic record keeping that is more stringent than that required by state or federal law or regulation.

(2) Within seven days after a price increase or decrease notification by a manufacturer, supplier, or nationally recognized source, a pharmacy benefit manager shall adjust its payment to the contracted pharmacy consistent with the price increase or decrease.

(3) A pharmacy benefit manager shall accept into its network any pharmacy or pharmacist if the pharmacy or pharmacist is licensed in good standing with the State of Nebraska. The pharmacy benefit manager shall not discriminate against the pharmacy or pharmacist with terms and conditions with regard to the class of trade.

(4) A pharmacy benefit manager shall not exclude a Nebraska pharmacy
from participation in its specialty pharmacy network as long as the pharmacy is willing to accept the terms of the pharmacy benefit manager's agreement with its specialty pharmacies.

(5) A pharmacy benefit manager shall not require a pharmacist or pharmacy to participate in one contract with a pharmacy benefit manager in order to participate in other contracts with the same pharmacy benefit manager.

(6) Covered individuals who use a mail-order pharmacy shall not be charged fees or higher copays to utilize a contracted pharmacy. A pharmacy benefit manager shall not prohibit a pharmacist or contracted pharmacy from mailing a prescription drug to a covered individual.

(7) A pharmacy benefit manager shall not mandate accreditation for a contracted pharmacy as a prerequisite to (a) mailing a prescription drug to a covered individual or reimbursing the contracted pharmacy for such drug or (b) participating in a network or plan.

Sec. 7. (1) A pharmacy benefit manager shall make readily available to the director and to each contracted pharmacy information related to the pharmacy benefit manager’s pricing methodology and reimbursement amount for single-source and multiple-source prescription drugs and compounds and specialty drugs.

(2) For purposes of the disclosure of pricing methodology, reimbursement amounts shall be:

(a) Established for multiple-source prescription drugs prescribed after the expiration of any generic drug exclusivity period;

(b) Established for any prescription drug with at least two or more therapeutically equivalent, multiple-source prescription drugs; and

(c) Determined using comparable prescription drug prices obtained from multiple nationally recognized comprehensive data sources, including wholesalers, prescription drug file vendors, and pharmaceutical manufacturers for prescription drugs that are nationally available and available for purchase locally by multiple pharmacies in the state.
(3) For those prescription drugs to which reimbursement amount pricing applies, a pharmacy benefit manager shall include in a contract with a contracted pharmacy information regarding which of the national compendia or other source is used to obtain pricing data used in the calculation of the reimbursement amount pricing and shall provide a process to allow a contracted pharmacy to comment on, contest, or appeal the reimbursement amount rates or reimbursement amount list. The right to comment on, contest, or appeal the reimbursement amount rates or reimbursement amount list shall be limited in duration and allow for retroactive payment if it is determined that reimbursement amount pricing has been applied incorrectly. The reimbursement amount shall be updated no less than every seven days by the pharmacy benefit manager.

Sec. 8. All financial benefits the pharmacy benefit manager receives, including, but not limited to, all rebates, discounts, credits, fees, grants, chargebacks, or other payments or financial benefits of any kind, shall be disclosed to the covered entity with which the pharmacy benefit manager contracts. The pharmacy benefit manager shall provide a copy of the pharmacy benefit manager's annual financial statements to the director each year on a date determined by the director.

Sec. 9. The pharmacy benefit manager shall disclose to the covered entity and to the contracted pharmacy the method used to calculate total dispensing fees, the cost of the prescription drug, administration fees, and any other fee payment, including, but not limited to, direct and indirect remuneration fees and fee recapture amounts. Fees and the amounts of such fees shall be clearly stated in the agreement between the contracted pharmacy and the pharmacy benefit manager. The pharmacy benefit manager shall not charge contracted pharmacies transaction-based or claims-processing fees.

Sec. 10. (1) All benefits payable under a pharmacy benefits management plan shall be paid as soon as feasible but no later than twenty days after receipt of a clean claim if the claim is submitted
electronically or thirty days after receipt of a clean claim if the claim
is submitted in paper format.

(2) Adjudication of a clean claim shall not be audited unless fraud
is suspected. Payments to the contracted pharmacy for clean claims are
considered to be overdue and not timely if not paid within the twenty-day
or thirty-day timeframe provided in subsection (1) of this section,
whichever is applicable. If any clean claim is not timely paid, the
pharmacy benefit manager shall pay the contracted pharmacy interest at
the rate of ten percent per annum commencing the day after any claim
payment or portion thereof was due until the claim is finally settled or
adjudicated in full.

(3) For purposes of this section, paid means the later of the day on
which the payment is mailed by the pharmacy benefit manager or the day on
which the electronic payment is processed by the pharmacy benefit
manager’s bank.

(4) A pharmacy benefit manager may demonstrate the date a claim is
paid by a mail record or a bank statement.

Sec. 11. (1) An audit of a contracted pharmacy's records by a
pharmacy benefit manager shall be conducted in accordance with the
following:

(a) The pharmacy benefit manager conducting the initial onsite audit
or the entity conducting such audit on the pharmacy benefit manager's
behalf shall provide the contracted pharmacy written notice at least two
weeks prior to conducting the audit. The notice shall be on the official
letterhead of the auditing entity and shall include the auditing entity’s
address and the name, signature, and phone number of the individual in
charge of the audit process;

(b) Any audit which involves clinical or professional judgment shall
be conducted by or in consultation with a pharmacist employed by the
pharmacy benefit manager;

(c) If a pharmacy benefit manager alleges an overpayment has been
made to a contracted pharmacy or pharmacist, the pharmacy benefit manager shall provide the contracted pharmacy or pharmacist sufficient documentation to determine the specific claims included in the alleged overpayment:

(d) A contracted pharmacy may use the records of a hospital, physician, or other licensed health care practitioner, written or transmitted by any means of communication, for purposes of validating the contracted pharmacy record with respect to medical orders or refills of a prescription drug;

(e) Each contracted pharmacy shall be audited under the same standards and parameters as other similarly situated pharmacies audited by the pharmacy benefit manager;

(f) The period covered by an audit shall not exceed two years from the date on which the claim was submitted to or adjudicated by a managed care company, an insurance company, a third-party payor, or any pharmacy benefit manager that represents such company or third-party payor;

(g) Unless otherwise consented to by the contracted pharmacy, an audit shall not be initiated or scheduled during the first seven calendar days of any month due to the high volume of prescriptions filled during that time;

(h) If a pharmacy benefit manager alleges an overpayment has been made to a contracted pharmacy, the alleged overpayment does not prohibit the contracted pharmacy from billing the covered individual for the drugs and services received. This subdivision does not apply if the drugs or services were never provided, were provided inappropriately, or were provided in violation of state law;

(i) The preliminary audit report shall be delivered to the contracted pharmacy within one hundred twenty days after conclusion of the audit. A final written audit report shall be delivered to the contracted pharmacy within six months after the preliminary audit report or final appeal, whichever is later; and
(j) A contracted pharmacy shall be allowed at least thirty days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during an audit.

(2) Notwithstanding any other provision in this section, the entity conducting the audit shall not use the accounting practice of extrapolation in calculating the recuperation of contractual penalties for audits.

(3) Recuperation of any disputed funds shall occur only after final disposition of the audit, including the appeals process as set forth in subsection (4) of this section.

(4) Each pharmacy benefit manager conducting an audit shall establish an appeals process under which a contracted pharmacy may appeal an unfavorable preliminary audit report to the pharmacy benefit manager. If, following the appeal, the pharmacy benefit manager finds that an unfavorable audit report or any portion thereof is unsubstantiated, the pharmacy benefit manager shall dismiss the audit report or the unsubstantiated portion without the necessity of any further proceedings. If, following the appeal, the pharmacy benefit manager finds that an unfavorable audit report or any portion thereof is substantiated, the pharmacy benefit manager shall have in place a process for an independent third-party review of the final audit findings. The pharmacy benefit manager shall notify the contracted pharmacy in writing of its right to request such third-party review and the process the contracted pharmacy should follow to do so.

(5) Each pharmacy benefit manager conducting an audit shall, after completion of any review process, provide a copy of the final audit report to the plan sponsor.

(6) The pharmacy benefit manager or the entity conducting the audit on its behalf shall not receive payment based on a percentage of the amount recovered. The auditing entity may charge the responsible party, directly or indirectly, based on amounts recouped if the covered entity
and the entity conducting the audit have a contract and the commission to
an agent or employee is based on amounts recouped.

(7) A clerical or record-keeping error in a submitted claim shall
not be recorded as fraud. The error shall be subject to recoupment of
dispensing fees but not the cost of the prescription drug. Errors that
have no financial harm to a covered individual or plan shall not result
in pharmacy benefit manager chargebacks.

(8) Interest shall not accrue during the audit period beginning with
the day the audit began and ending with the day the final written audit
report is delivered.

(9) This section shall not apply to any investigative audit that
involves fraud, willful misrepresentation, or abuse or to any other
statutory provision which authorizes investigations relating to, but not
limited to, insurance fraud.

Sec. 12. A pharmacy benefit manager shall mail an explanation of
benefits to the covered individual for each of the covered individual’s
pharmacy claims for a prescription drug that is covered or managed by the
pharmacy benefit manager. The explanation of benefits shall include the
cost of the prescription drug being charged to the covered entity, the
pharmacy benefit manager’s payment, the copayment paid by the covered
individual, the fees and other charges deducted from the cost of the
drug, and the final payment to the pharmacy. The pharmacy benefit manager
shall not prohibit the pharmacist from disclosing the cost of the
prescription drug or what the contracted pharmacy was reimbursed to a
covered individual or a covered individual’s caregiver.

Sec. 13. A pharmacist or contracted pharmacy shall not be
prohibited from or subject to penalties or removal from a network or plan
for sharing information regarding the cost, price, or copayment of a
prescription drug with a covered individual or a covered individual’s
caregiver.

Sec. 14. A covered entity that contracts with a pharmacy benefit
manager to perform pharmacy benefits management services shall require the pharmacy benefit manager to notify the department of any detection of fraud, including, but not limited to, prescription drug diversion activity.

Sec. 15. The director may adopt and promulgate rules and regulations to carry out the Pharmacy Benefit Fairness and Transparency Act.