State PBM Reform Inventory

Updated October 2026

Nebraska

Issue	Summary	Citation
Licensing/Registration	A person shall not establish or operate as a PBM in this state for a health benefit plan without first obtaining a license from the Director of Insurance. A person applying for a PBM license shall apply for licensure in the form and manner prescribed by the director and shall pay a non-refundable fee of $500. PBM licenses must be renewed annually, with a $250 renewal fee.	NRS § 44-4605
Reporting Requirements	N/A	
PBM Income	**Spread Pricing:** A contract between a PBM 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. Beginning January 1, 2029, no contract between a PBM and a health benefit plan shall include spread pricing.	NRS § 44-4617
Pharmacy Contracting	**MAC Pricing:** With respect to each contract and contract renewal between a PBM and a pharmacy, the PBM shall: • Update any MAC price list at least every 7 business days, noting any price change from the previous list, and provide a means by which a network pharmacy may promptly review a current price in an electronic, print, or telephonic format within 1 business day of any such change at no cost to the pharmacy; • Maintain a procedure to eliminate a product from the MAC price list in a timely manner to remain consistent with any change in the marketplace; and • Make the MAC price list available to each contracted pharmacy in a format that is readily accessible and usable to the contracted pharmacy.	NRS § 44-4608; NRS § 44-4614

	A PBM shall not place a prescription drug on a MAC price list unless the drug is available for purchase by pharmacies in this state from a national or regional drug wholesaler and is not obsolete.
	
	Each contract between a PBM and a pharmacy shall include a process to appeal, investigate, and resolve disputes regarding any MAC price. The process shall include:
	• A 15-business-day limit on the right to appeal following submission of an initial claim by a pharmacy;
	• A requirement that any appeal be investigated and resolved within 7 business days after the appeal is received by the PBM; and
	• A requirement that the PBM provide a reason for any denial of an appeal and identify the NDC for the drug that may be purchased by the pharmacy at a price at or below the price on the MAC price list as determined by the PBM.
	• If an appeal is determined to be valid by the PBM, the PBM shall:
	  ○ Make an adjustment in the drug price no later than 1 day after the appeal is resolved; and
	  ○ Permit the appealing pharmacy to reverse and rebill the claim in question, using the date of the original claim.
	
	Patient Steering:
	A health benefit plan, health carrier, or PBM shall not:
	• Require a covered person to obtain pharmacist services exclusively through the mail-order pharmacy or PBM affiliate;
	• Prohibit or limit a covered person from selecting a network pharmacist or network pharmacy of the covered person's choice;
	• Transfer a covered person's prescriptions from a network pharmacy to another pharmacy unless requested by the covered person;
	• Use financial incentives, including, but not limited to, adjustments in cost-sharing obligations of a covered person, to the exclusive benefit of the PBM affiliate pharmacy; or
	• Auto-enroll a covered person in mail-order pharmacist services, except in the case of a maintenance medication	

	after the first 90 days where the covered person may opt-out.	
Patient Cost-Sharing	**Maximum Cost-Sharing Levels:** A PBM shall not require a covered person purchasing a covered prescription drug to pay an amount greater than the lesser of the covered person's cost-sharing amount under the terms of the health benefit plan or the amount the covered person would pay for the drug if the covered person were paying the cash price. Any amount paid shall be attributable to any deductible or out-of-pocket maximum under the covered person's health benefit plan. **Copay Cap:** Starting January 1, 2024, plans shall limit the total amount that a covered individual is required to pay for each covered prescription insulin drug on the policy's, contract's, or plan's lowest brand or generic tier to a maximum of thirty-five dollars per thirty-day supply of insulin, regardless of the amount needed. If, due to a national shortage of an insulin drug, a covered individual cannot access a covered prescription insulin drug on the lowest brand or generic tier of the policy, contract, or plan, the policy, contract, or plan shall ensure access to an insulin drug at a maximum of thirty-five dollars per thirty-day supply, until such time that the national shortage ends to prevent disruptions in patient access to insulin. This requirement applies to self-funded health plans governed by ERISA unless preempted by federal law.	NRS § 44-4606; NRS § 44-790.01