Amendment No. 282

Senate Amendment to Senate Bill No. 325 (BDR 54-632)
Proposed by: Senate Committee on Health and Human Services
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 325 (§§ 4, 5).

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

SRF/EWR Date: 4/17/2021

S.B. No. 325—Establishes provisions relating to preventing the acquisition of human immunodeficiency virus. (BDR 54-632)

SENATE BILL NO. 325–SENATOR SETTELMEYER

MARCH 22, 2021

Referred to Committee on Health and Human Services

SUMMARY—Establishes provisions relating to preventing the acquisition of human immunodeficiency virus. (BDR 54-632)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§§ 4, 5)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to health care; requiring the State Board of Pharmacy to prescribe a protocol authorizing a pharmacist to prescribe and dispense drugs to prevent the acquisition of human immunodeficiency virus and perform certain laboratory tests; requiring certain health plans to include coverage for such drugs and testing; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law defines the term "practice of pharmacy" for the purpose of determining which activities require a person to be registered and regulated by the State Board of Pharmacy as a pharmacist. (NRS 639.0124) **Section 1** of this bill requires the State Board of Pharmacy to prescribe a protocol to allow a pharmacist to: (1) order any laboratory test necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus; (2) conduct such tests as necessary for such therapy; and (3) prescribe and dispense such drugs without a prescription from a practitioner. **Section 1** authorizes a pharmacist who is covered by sufficient liability coverage, as defined by regulations adopted by the Board, to take the actions authorized by the protocol. **Section 2** of this bill provides that the practice of pharmacy includes actions authorized by the protocol. **Section 8.5 of this bill makes a conforming change to account for the provisions of section 1 authorizing a pharmacist to dispense a drug that has not been prescribed by a practitioner.** The Board would be authorized to suspend or revoke the registration of a pharmacist who orders or conducts a laboratory test or prescribes or dispenses drugs under the protocol issued pursuant to **section 1** without complying with the provisions of the protocol. (NRS 639.210)

Sections 4-7, 10, 12, 13, 15-17 and 20 of this bill require public and private health plans, including Medicaid and health plans for state and local government employees, to: (1) provide coverage for drugs that prevent the acquisition of human immunodeficiency virus and any related laboratory or diagnostic procedures; and (2) reimburse laboratory testing, prescribing and dispensing by a pharmacist in accordance with **section 1** at a rate equal to that provided to a physician, physician assistant or advanced practice registered nurse for similar services. **Sections 4, 5, 8-10, 12, 13, 15-17 and 20** of this bill prohibit such a health plan from requiring prior authorization or step therapy. **Sections 3, 11 and 14** of this bill make conforming

changes to indicate the placement of **sections 6, 10 and 13**, respectively, of this bill in the Nevada Revised Statutes. **Section 19** of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of **section 17** of this bill. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of **sections 10, 12, 13, 15, 16 and 20** of this bill. (NRS 680A.200)

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 639 of NRS is hereby amended by adding thereto a new section to read as follows:

1. To the extent authorized by federal law, a pharmacist who meets the requirements prescribed by the Board pursuant to subsection 2 may, in accordance with the requirements of the protocol prescribed pursuant to subsection 2:

(a) Order and perform laboratory tests that are necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus; and

(b) Prescribe and dispense any drug described in paragraph (a) to a patient.

2. The Board shall adopt regulations:

(a) Requiring a pharmacist who takes the actions authorized by this section to be covered by adequate liability insurance, as determined by the Board; and

(b) Establishing a protocol for the actions authorized by this section.

Sec. 2. NRS 639.0124 is hereby amended to read as follows:

639.0124 ***1.*** "Practice of pharmacy" includes, but is not limited to, the:

~~[1.]~~ ***(a)*** Performance or supervision of activities associated with manufacturing, compounding, labeling, dispensing and distributing of a drug, including the receipt, handling and storage of prescriptions and other confidential information relating to patients.

~~[2.]~~ ***(b)*** Interpretation and evaluation of prescriptions or orders for medicine.

~~[3.]~~ ***(c)*** Participation in drug evaluation and drug research.

~~[4.]~~ ***(d)*** Advising of the therapeutic value, reaction, drug interaction, hazard and use of a drug.

~~[5.]~~ ***(e)*** Selection of the source, storage and distribution of a drug.

~~[6.]~~ ***(f)*** Maintenance of proper documentation of the source, storage and distribution of a drug.

~~[7.]~~ ***(g)*** Interpretation of clinical data contained in a person's record of medication.

~~[8.]~~ ***(h)*** Development of written guidelines and protocols in collaboration with a practitioner which are intended for a patient in a licensed medical facility or in a setting that is affiliated with a medical facility where the patient is receiving care and which authorize collaborative drug therapy management. The written guidelines and protocols must comply with NRS 639.2629.

~~[9.]~~ ***(i)*** Implementation and modification of drug therapy, administering drugs and ordering and performing tests in accordance with a collaborative practice agreement.

(j) Prescribing and dispensing of drugs for preventing the acquisition of human immunodeficiency virus and ordering and conducting laboratory tests necessary for therapy that uses such drugs pursuant to the protocol prescribed pursuant to section 1 of this act.

~~[➥]~~

2. The term does not include the changing of a prescription by a pharmacist or practitioner without the consent of the prescribing practitioner, except as otherwise provided in NRS 639.2583 ~~.~~ ***and section 1 of this act.***

Sec. 3. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 6 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 4. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and section 12 of this act,*** 689B.287 and 689B.500 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and

the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 5. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, 689B.255, 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 20 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 6. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

1. Any laboratory testing that is necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus; and

2. The services of a pharmacist described in section 1 of this act. The State must provide reimbursement for such services at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

Sec. 7. NRS 422.4025 is hereby amended to read as follows:

422.4025 1. The Department shall:

(a) By regulation, develop a list of preferred prescription drugs to be used for the Medicaid program and the Children's Health Insurance Program, and each public or nonprofit health benefit plan that elects to use the list of preferred prescription drugs as its formulary pursuant to NRS 287.012, 287.0433 or 687B.407; and

(b) Negotiate and enter into agreements to purchase the drugs included on the list of preferred prescription drugs on behalf of the health benefit plans described in paragraph (a) or enter into a contract pursuant to NRS 422.4053 with a pharmacy benefit manager or health maintenance organization, as appropriate, to negotiate such agreements.

2. The Department shall, by regulation, establish a list of prescription drugs which must be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs established pursuant to subsection 1. The list established pursuant to this subsection must include, without limitation:

(a) Prescription drugs that are prescribed for the treatment of the human immunodeficiency virus or acquired immunodeficiency syndrome, including, without limitation, protease inhibitors and antiretroviral medications;

(b) Antirejection medications for organ transplants;

(c) Antihemophilic medications; and

(d) Any prescription drug which the Board identifies as appropriate for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs.

3. The regulations must provide that the Board makes the final determination of:

(a) Whether a class of therapeutic prescription drugs is included on the list of preferred prescription drugs and is excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs;

(b) Which therapeutically equivalent prescription drugs will be reviewed for inclusion on the list of preferred prescription drugs and for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs; and

(c) Which prescription drugs should be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs based on continuity of care concerning a specific diagnosis, condition, class of therapeutic prescription drugs or medical specialty.

4. The list of preferred prescription drugs established pursuant to subsection 1 must include, without limitation ~~[, any]~~ ***:***

(a) Any prescription drug determined by the Board to be essential for treating sickle cell disease and its variants ~~[.]~~ ***; and***

(b) Prescription drugs to prevent the acquisition of human immunodeficiency virus.

5. The regulations must provide that each new pharmaceutical product and each existing pharmaceutical product for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs must be made available pursuant to the Medicaid program with prior authorization until the Board reviews the product or the evidence.

6. On or before February 1 of each year, the Department shall:

(a) Compile a report concerning the agreements negotiated pursuant to paragraph (b) of subsection 1 and contracts entered into pursuant to NRS 422.4053 which must include, without limitation, the financial effects of obtaining prescription drugs through those agreements and contracts, in total and aggregated separately for agreements negotiated by the Department, contracts with a pharmacy benefit manager and contracts with a health maintenance organization; and

(b) Post the report on an Internet website maintained by the Department and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In odd-numbered years, the Legislature; or

(2) In even-numbered years, the Legislative Commission.

Sec. 8. NRS 422.403 is hereby amended to read as follows:

422.403 1. The Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. The Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures for use by the Medicaid program for prescription drugs; and

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.

3. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed pursuant to NRS 422.4025.

4. The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.

5. The Department shall not require a recipient of Medicaid to undergo step therapy for a prescription drug for the prevention of human immunodeficiency virus.

Sec. 8.5. **NRS 683A.179 is hereby amended to read as follows:**

683A.179 1. A pharmacy benefit manager shall not:

(a) Prohibit a pharmacist or pharmacy from providing information to a covered person concerning:

(1) The amount of any copayment or coinsurance for a prescription drug; or

(2) The availability of a less expensive alternative or generic drug including, without limitation, information concerning clinical efficacy of such a drug;

(b) Penalize a pharmacist or pharmacy for providing the information described in paragraph (a) or selling a less expensive alternative or generic drug to a covered person;

(c) Prohibit a pharmacy from offering or providing delivery services directly to a covered person as an ancillary service of the pharmacy; or

(d) If the pharmacy benefit manager manages a pharmacy benefits plan that provides coverage through a network plan, charge a copayment or coinsurance for a prescription drug in an amount that is greater than the total amount paid to a pharmacy that is in the network of providers under contract with the third party.

2. The provisions of this section:

(a) Must not be construed to authorize a pharmacist to dispense a drug that has not been prescribed by a practitioner, as defined in NRS 639.0125 ~~.~~ ***, except to the extent authorized by section 1 of this act.***

(b) Do not apply to an institutional pharmacy, as defined in NRS 639.0085, or a pharmacist working in such a pharmacy as an employee or independent contractor.

3. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with

the carrier. The term does not include an arrangement for the financing of premiums.

Sec. 9. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 10, 12, 13, 15, 16 and 19 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 10. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of health insurance shall reimburse a pharmacist who participates in the network plan of the insurer for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. An insurer shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. An insurer shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 11. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or

corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~.~~ ***, and section 10 of this act.***

Sec. 12. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of group health insurance shall reimburse a pharmacist who participates in the network plan of the insurer for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. An insurer shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. An insurer shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 13. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the health benefit plan of the carrier.

2. A carrier that offers or issues a health benefit plan shall reimburse a pharmacist who participates in the health benefit plan of the carrier for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A carrier shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. A carrier shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 14. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and section 13 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 15. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A society that offers or issues a benefit contract shall include in the benefit coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the society.

2. A society that offers or issues a benefit contract shall reimburse a pharmacist who participates in the network plan of the society for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A society shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. A society shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 16. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy using such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the hospital or medical services corporation.

2. A hospital or medical services corporation that offers or issues a policy of health insurance shall reimburse a pharmacist who participates in the network plan of the hospital or medical services corporation for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A hospital or medical services corporation shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. A hospital or medical services corporation shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the hospital or medical services corporation.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 17. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the health maintenance organization.

2. A health maintenance organization that offers or issues a health care plan shall reimburse a pharmacist who participates in the network plan of the health maintenance organization for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A health maintenance organization shall not require an enrollee to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. A health maintenance organization shall ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 18. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and 695C.1757 ***, and section 17 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 19. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***or section 17 of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 20. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) Any drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in section 1 of this act, when provided by a pharmacist who participates in the network plan of the managed care organization.

2. A managed care organization that offers or issues a health care plan shall reimburse a pharmacist who participates in the network plan of the managed care organization for the services described in section 1 of this act at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. A managed care organization shall not require an insured to undergo step therapy or receive prior authorization in order to receive the benefits required by subsection 1.

4. A managed care organization shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 21. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 22. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 21, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On October 1, 2021, for all other purposes.