S.B. 226

SENATE BILL NO. 226–SENATORS SPEARMAN, PARKS; AND HARRIS

FEBRUARY 18, 2019

Referred to Committee on Health and Human Services

SUMMARY—Makes various changes relating to health insurance. (BDR 38-549)

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

CONTAINS UNFUNDED MANDATE (§ 15)
(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 insurance; requiring the Department of Health and Human Services to enter into agreements to purchase prescription drugs on behalf of certain health benefit plans; authorizing the Department to enter into agreements to purchase other goods or services on behalf of such health benefit plans; replacing the Pharmacy and Therapeutics Committee with the Silver State Scripts Advisory Board; requiring certain insurers to participate in a system that rates health care plans; requiring an insurer to allow an insured to credit certain amounts toward any copay or coinsurance for a prescription drug; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

1 Existing law requires the Department of Health and Human Services to develop
2 a list of preferred prescription drugs to be used for the Medicaid program. (NRS
3 422.4025) **Section 7** of this bill instead requires the Department to: (1) develop a
4 formulary of prescription drugs to be used for all health benefit plans funded by a
5 state agency or local governmental entity in this State that provide coverage for
6 prescription drugs, including the Medicaid program and Children's Health
7 Insurance Program, and each nonprofit health benefit plan that elects to use the
8 formulary; and (2) negotiate and enter into agreements to purchase prescription
9 drugs included in that formulary on behalf of those health benefit plans or enter into
10 a contract with an insurer or pharmacy benefit manager to negotiate and enter into
11 such agreements. **Section 7** also requires the Department to report annually to the
12 Legislature the amount of money saved by those health benefit plans through such
13 purchasing agreements. **Sections 15, 16 and 28** of this bill require each health

14 benefit plan that provides prescription drug coverage for public employees and each
15 managed care organization that provides health care services to recipients of
16 Medicaid or insurance pursuant to the Children's Health Insurance Program to use
17 the formulary and provide for prescription drugs to be obtained through the
18 purchasing agreements negotiated by the Department. **Section 19** of this bill
19 authorizes a nonprofit health benefit plan to use the formulary developed by the
20 Department and obtain prescription drugs or other services through the purchasing
21 agreements negotiated by the Department. **Sections 7, 15, 16 and 28** of this bill
22 authorize the Department to: (1) negotiate and enter into agreements to purchase
23 benefits in addition to prescription drugs on behalf of publicly funded and nonprofit
24 health benefit plans that opt in to such purchasing agreements; or (2) enter into a
25 contract with an insurer or pharmacy benefit manager to negotiate and enter into
26 such agreements. **Sections 2-5, 8 and 13** of this bill make conforming changes.
27 Existing law requires the Director of the Department to create a Pharmacy and
28 Therapeutics Committee within the Department, consisting of members appointed
29 by the Governor based on recommendations of the Director. (NRS 422.4035)
30 Existing law requires the Committee to identify: (1) prescription drugs for inclusion
31 in the list of preferred prescription drugs for the Medicaid program; and (2)
32 prescription drugs on that list which should be excluded from any restrictions
33 imposed by the Medicaid program. (NRS 422.405) **Sections 9-12** of this bill
34 replace the Committee with the Silver State Scripts Advisory Board. **Section 9** of
35 this bill prescribes the membership of the Board. **Section 12** of this bill requires the
36 Board to: (1) identify prescription drugs for inclusion in the formulary developed
37 for use by publicly funded and nonprofit health plans; and (2) assume the other
38 duties of the Committee.
39 Existing law requires the Committee to make its decisions based on evidence of
40 clinical efficacy and safety without consideration of cost. (NRS 422.405) **Section**
41 **12** authorizes the Board to consider cost if there is no significant difference in the
42 clinical efficacy, safety and patient outcomes of two or more drugs. **Sections 12**
43 **and 14** of this bill authorize the Board to close a portion of a meeting to the public
44 in order to consider the cost of prescription drugs.
45 Existing law requires the Division of Insurance of the Department of Business
46 and Industry to establish a toll-free telephone service for receiving inquiries and
47 complaints from consumers of health care in this State concerning health care
48 plans. (NRS 679B.550) **Section 17** of this bill requires the Department of Health
49 and Human Services to adopt regulations to require each insurer that offers a health
50 care plan in this State to: (1) participate in a system that rates each such health care
51 plan on customer satisfaction and coverage for treatment and preventative care; and
52 (2) notify consumers of health care of the rating of each health care plan offered by
53 the insurer. **Section 18** of this bill makes a conforming change.
54 Existing law requires an insurer, other than a health benefit plan for public
55 employees, that provides coverage for prescription drugs to provide an insured with
56 certain information concerning prescription drug coverage. (NRS 689A.405,
57 689B.0283, 689C.281, 689C.455, 695A.255, 695B.176, 695C.1703, 695F.153,
58 695G.163) **Sections 15, 16 and 18-28** of this bill require an insurer, including a
59 health benefit plan for public employees, to allow an insured to credit any amount
60 saved by using a coupon for a prescription drug toward any copay or coinsurance
61 that the insured is required to pay for the prescription drug.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***"Health benefit plan" means a policy, contract, certificate or agreement offered to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.***

Sec. 3. ***"Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.***

Sec. 4. NRS 422.27172 is hereby amended to read as follows:

422.27172 1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;

(c) Insertion or removal of a device for contraception;

(d) Education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. The Director shall ensure that the provisions of this section are carried out in a manner which complies with the requirements established by the Drug Use Review Board and set forth in the ~~[list of preferred prescription drugs]~~ ***formulary*** established by the Department pursuant to NRS 422.4025.

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

5. For each method of contraception which is approved by the Food and Drug Administration, the Plan must include at least one contraceptive drug or device for which no deductible, copayment or

coinsurance may be charged to the person enrolled in Medicaid, but the Plan may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception.

6. As used in this section:

(a) "Drug Use Review Board" has the meaning ascribed to it in NRS 422.402.

(b) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 5. NRS 422.401 is hereby amended to read as follows:

422.401 As used in NRS 422.401 to 422.406, inclusive, ***and sections 2 and 3 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 422.4015 and 422.402 ***and sections 2 and 3 of this act*** have the meanings ascribed to them in those sections.

Sec. 6. NRS 422.4015 is hereby amended to read as follows:

422.4015 ~~["Committee"]~~ ***"Board"*** means the ~~[Pharmacy and Therapeutics Committee]~~ ***Silver State Scripts Advisory Board*** established pursuant to NRS 422.4035.

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

422.4025 1. The Department shall ~~[, by]~~ ***:***

(a) By regulation, develop a ~~[list of preferred]~~ ***formulary of*** prescription drugs to be used for ***all health benefit plans funded by a state agency or local governmental entity in this State that provide coverage for prescription drugs, including, without limitation,*** the Medicaid program ~~[.]~~ ***and the Children's Health Insurance Program, and each nonprofit health benefit plan that elects to use the formulary pursuant to section 19 of this act; and***

(b) Negotiate and enter into agreements to purchase the drugs included in the formulary on behalf of the health benefit plans described in paragraph (a) or enter into a contract with a private insurer or pharmacy benefit manager to negotiate such agreements.

2. ***The Department may:***

(a) Negotiate and enter into agreements to purchase dental and vision benefits, hearing aids and other goods and services in addition to those required by subsection 1 for persons who receive coverage through the Medicaid program or a health plan that opts

in to such a purchasing agreement pursuant to NRS 287.043 or 695G.163 or section 15 of this act; or

(b) Enter into a contract with a private insurer or pharmacy benefit manager to negotiate and enter into the agreements described in paragraph (a).

3. 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]~~ ***included in*** the ~~[list of preferred prescription drugs]~~ ***formulary*** established pursuant to subsection 1. The list established pursuant to this subsection must include, without limitation:

(a) Atypical and typical antipsychotic medications that are prescribed for the treatment of a mental illness of a patient who is receiving services pursuant to Medicaid;

(b) 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;

(c) Anticonvulsant medications;

(d) Antirejection medications for organ transplants;

(e) Antidiabetic medications;

(f) Antihemophilic medications; and

(g) Any prescription drug which the ~~[Committee]~~ ***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.]~~ ***included in the formulary.***

~~[3.]~~ ***4.*** The regulations must provide that the ~~[Committee]~~ ***Board*** makes the final determination of:

(a) Whether a class of therapeutic prescription drugs is included ~~[on the list of preferred prescription drugs and]~~ ***in the formulary or*** is excluded from any restrictions that are imposed ***by the Medicaid program*** on drugs that are ~~[on the list of preferred prescription drugs;]~~ ***included in the formulary;***

(b) Which therapeutically equivalent prescription drugs will be reviewed for inclusion ~~[on the list of preferred prescription drugs and]~~ ***in the formulary or*** for exclusion from any restrictions that are imposed ***by the Medicaid program*** on drugs that are ~~[on the list of preferred prescription drugs;]~~ ***included in the formulary;*** 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]~~ ***included in the formulary*** based on continuity of care concerning a specific diagnosis, condition, class of therapeutic prescription drugs or medical specialty.

1 ~~[4.]~~ ***5.*** The regulations must provide that each new
2 pharmaceutical product and each existing pharmaceutical product
3 for which there is new clinical evidence supporting its inclusion ~~[on~~
4 ~~the list of preferred prescription drugs]~~ ***in the formulary*** must be
5 made available pursuant to the Medicaid program with prior
6 authorization until the ~~[Committee]~~ ***Board*** reviews the product or
7 the evidence.
8 ***6. On or before February 1 of each year, the Department***
9 ***shall:***
10 ***(a) Compile a report concerning the agreements negotiated***
11 ***pursuant to subsections 1 and 2, which must include, without***
12 ***limitation, the total amount of money saved by the health benefit***
13 ***plans described in paragraph (a) of subsection 1 by obtaining***
14 ***prescription drugs through those agreements; and***
15 ***(b) Submit the report to the Director of the Legislative Counsel***
16 ***Bureau for transmittal to:***
17 ***(1) In odd-numbered years, the Legislature; or***
18 ***(2) In even-numbered years, the Legislative Commission.***
19 **Sec. 8.** NRS 422.403 is hereby amended to read as follows:
20 422.403 1. The Department shall, by regulation, establish and
21 manage the use by the Medicaid program of step therapy and prior
22 authorization for prescription drugs.
23 2. The Drug Use Review Board shall:
24 (a) Advise the Department concerning the use by the Medicaid
25 program of step therapy and prior authorization for prescription
26 drugs;
27 (b) Develop step therapy protocols and prior authorization
28 policies and procedures for use by the Medicaid program for
29 prescription drugs; and
30 (c) Review and approve, based on clinical evidence and best
31 clinical practice guidelines and without consideration of the cost of
32 the prescription drugs being considered, step therapy protocols used
33 by the Medicaid program for prescription drugs.
34 3. The Department shall not require the Drug Use Review
35 Board to develop, review or approve prior authorization policies or
36 procedures necessary for the operation of the ~~[list of preferred~~
37 ~~prescription drugs]~~ ***formulary*** developed ~~[for the Medicaid~~
38 ~~program]~~ pursuant to NRS 422.4025.
39 4. The Department shall accept recommendations from the
40 Drug Use Review Board as the basis for developing or revising step
41 therapy protocols and prior authorization policies and procedures
42 used by the Medicaid program for prescription drugs.
43 **Sec. 9.** NRS 422.4035 is hereby amended to read as follows:
44 422.4035 1. The Director shall create ~~[a Pharmacy and~~
45 ~~Therapeutics Committee]~~ ***the Silver State Scripts Advisory Board***

within the Department. The [Committee] ***Board*** must consist of [at least 5] ***such*** members [and not more than 11 members] ***as are*** appointed by the [Governor based on recommendations from the] Director.

2. [The Governor shall appoint to the Committee health care professionals who have knowledge and expertise in one or more of the following:

(a) The clinically appropriate prescribing of outpatient prescription drugs that are covered by Medicaid;

(b) The clinically appropriate dispensing and monitoring of outpatient prescription drugs that are covered by Medicaid;

(c) The review of, evaluation of and intervention in the use of prescription drugs; and

(d) Medical quality assurance.

3. At least one third of the members of the Committee must be active physicians licensed to practice medicine in this State, at least one of whom must be an active psychiatrist licensed to practice medicine in this State. At least one third of the members of the Committee must be either active pharmacists registered in this State or persons in this State with doctoral degrees in pharmacy.

4.] ***The appointed members of the Board serve at the pleasure of the Director.***

3. A person must not be appointed to the [Committee] ***Board*** if the person is employed by, compensated by in any manner, has a financial interest in, or is otherwise affiliated with a business or corporation that manufactures prescription drugs.

Sec. 10. NRS 422.404 is hereby amended to read as follows:

422.404 1. The [Governor] ***Director*** shall appoint the Chair of the [Committee] ***Board*** from among its members.

2. [After the initial terms, the term of each member of the Committee is 2 years. A member may be reappointed.

3. A vacancy occurring in the membership of the Committee must be filled for the remainder of the unexpired term in the same manner as the original appointment.

4.] The [Committee] ***Board*** shall meet at least once every 3 months and at the times and places specified by a call of the Chair of the [Committee.] ***Board.***

[5.] ***3.*** A majority of the members of the [Committee] ***Board*** constitutes a quorum for the transaction of business, and the affirmative vote of a majority of the members of the [Committee] ***Board*** is required to take action.

Sec. 11. NRS 422.4045 is hereby amended to read as follows:

422.4045 1. Members of the [Committee] ***Board*** serve without compensation, except that a member of the [Committee] ***Board*** is entitled, while engaged in the business of the [Committee,]

Board, to receive the per diem allowance and travel expenses provided for state officers and employees generally.

2. Each member of the ~~[Committee]~~ ***Board*** who is an officer or employee of the State of Nevada or a local government must be relieved from his or her duties without loss of regular compensation so that the person may prepare for and attend meetings of the ~~[Committee]~~ ***Board*** and perform any work necessary to carry out the duties of the ~~[Committee]~~ ***Board*** in the most timely manner practicable. A state agency or local governmental entity shall not require an officer or employee who is a member of the ~~[Committee]~~ ***Board*** to make up the time that the officer or employee is absent from work to carry out any duties as a member of the ~~[Committee]~~ ***Board*** or to use annual vacation or compensatory time for the absence.

Sec. 12. NRS 422.405 is hereby amended to read as follows:

422.405 1. The Department shall, by regulation, set forth the duties of the ~~[Committee]~~ ***Board,*** which must include, without limitation:

(a) Identifying the prescription drugs which should be included ~~[on]~~ ***in*** the ~~[list of preferred prescription drugs]~~ ***formulary*** developed by the Department for the ~~[Medicaid program pursuant to]~~ ***health benefit plans described in paragraph (a) of subsection 1 of*** NRS 422.4025 ~~[and]~~ ***, which must include, without limitation, any prescription drug required by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services to be covered by the Medicaid program and any other prescription drug deemed essential by the Board;***

(b) Identifying the prescription drugs which should be excluded from any restrictions that are imposed ***by the Medicaid program*** on drugs that are ~~[on the list of preferred prescription drugs;]~~ ***included in the formulary;***

~~[(b)]~~ ***(c)*** Identifying classes of therapeutic prescription drugs for its review and performing a clinical analysis of each drug included in each class that is identified for review; and

~~[(c)]~~ ***(d)*** Reviewing at least annually all classes of therapeutic prescription drugs ~~[on the list of preferred prescription drugs]~~ ***included in the formulary*** developed by the Department for the ~~[Medicaid program pursuant to]~~ ***health benefit plans described in paragraph (a) of subsection 1 of*** NRS 422.4025.

2. The Department shall, by regulation, require the ~~[Committee]~~ ***Board*** to:

(a) Base its decisions on evidence of clinical efficacy ***,*** ~~[and]~~ safety ~~[without consideration of the cost of the prescription drugs being considered by the Committee;]~~ ***and outcomes for patients***

1 ***and, if the difference between the clinical efficacy, safety and***
2 ***outcomes for two or more drugs is not clinically significant, cost;***
3 (b) Review new pharmaceutical products in as expeditious a
4 manner as possible; and
5 (c) Consider new clinical evidence supporting the inclusion of
6 an existing pharmaceutical product [on the list of preferred
7 prescription drugs] ***in the formulary*** developed by the Department
8 for the [Medicaid program] ***health benefit plans described in***
9 ***paragraph (a) of subsection 1 of NRS 422.4025*** and new clinical
10 evidence supporting the exclusion of an existing pharmaceutical
11 product from any restrictions that are imposed ***by the Medicaid***
12 ***program*** on drugs that are [on the list of preferred prescription
13 drugs] ***included in the formulary*** in as expeditious a manner as
14 possible.
15 3. The Department shall, by regulation, authorize the
16 [Committee] ***Board*** to:
17 (a) In carrying out its duties, exercise clinical judgment and
18 analyze peer review articles, published studies, and other medical
19 and scientific information; and
20 (b) Establish subcommittees to analyze specific issues that arise
21 as the [Committee] ***Board*** carries out its duties.
22 ***4. The Board may close any portion of a meeting during***
23 ***which it considers the cost of prescription drugs.***
24 **Sec. 13.** NRS 422.406 is hereby amended to read as follows:
25 422.406 1. The Department may, to carry out its duties set
26 forth in NRS 422.27172 to 422.27178, inclusive, and 422.401 to
27 422.406, inclusive, ***and sections 2 and 3 of this act*** and to
28 administer the provisions of those sections:
29 (a) Adopt regulations; and
30 (b) Enter into contracts for any services.
31 2. Any regulations adopted by the Department pursuant to NRS
32 422.27172 to 422.27178, inclusive, and 422.401 to 422.406,
33 inclusive, ***and sections 2 and 3 of this act*** must be adopted in
34 accordance with the provisions of chapter 241 of NRS.
35 **Sec. 14.** NRS 241.016 is hereby amended to read as follows:
36 241.016 1. The meetings of a public body that are quasi-
37 judicial in nature are subject to the provisions of this chapter.
38 2. The following are exempt from the requirements of this
39 chapter:
40 (a) The Legislature of the State of Nevada.
41 (b) Judicial proceedings, including, without limitation,
42 proceedings before the Commission on Judicial Selection and,
43 except as otherwise provided in NRS 1.4687, the Commission on
44 Judicial Discipline.

(c) Meetings of the State Board of Parole Commissioners when acting to grant, deny, continue or revoke the parole of a prisoner or to establish or modify the terms of the parole of a prisoner.

3. Any provision of law, including, without limitation, NRS 91.270, 219A.210, 228.495, 239C.140, 281A.350, 281A.690, 281A.735, 281A.760, 284.3629, 286.150, 287.0415, 287.04345, 287.338, 288.220, 289.387, 295.121, 360.247, 388.261, 388A.495, 388C.150, 388G.710, 388G.730, 392.147, 392.467, 394.1699, 396.3295, ***422.405,*** 433.534, 435.610, 463.110, 622.320, 622.340, 630.311, 630.336, 631.3635, 639.050, 642.518, 642.557, 686B.170, 696B.550, 703.196 and 706.1725, which:

(a) Provides that any meeting, hearing or other proceeding is not subject to the provisions of this chapter; or

(b) Otherwise authorizes or requires a closed meeting, hearing or proceeding,

➥ prevails over the general provisions of this chapter.

4. The exceptions provided to this chapter, and electronic communication, must not be used to circumvent the spirit or letter of this chapter to deliberate or act, outside of an open and public meeting, upon a matter over which the public body has supervision, control, jurisdiction or advisory powers.

Sec. 15. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada establishes coverage for prescription drugs pursuant to NRS 287.010 or 287.015 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, such coverage must:

(a) Use the formulary developed by the Department of Health and Human Services pursuant to subsection 1 of NRS 422.4025 and provide for prescription drugs to be obtained through the purchasing agreements negotiated by the Department pursuant to that section; and

(b) Allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

2. The governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance pursuant to NRS 287.010 or 287.015 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025 may opt in to participate in a purchasing agreement negotiated by or pursuant to a contract with the Department under the provisions of subsection 2 of NRS 422.4025 for any goods or services by

1 ***notifying the Department in the form prescribed by the***
2 ***Department.***
3 **Sec. 16.** NRS 287.043 is hereby amended to read as follows:
4 287.043 1. The Board shall:
5 (a) Establish and carry out a program to be known as the Public
6 Employees' Benefits Program which:
7 (1) Must include a program relating to group life, accident or
8 health insurance, or any combination of these; and
9 (2) May include:
10 (I) A plan that offers flexibility in benefits, and for which
11 the rates must be based only on the experience of the participants in
12 the plan and not in combination with the experience of participants
13 in any other plan offered under the Program; or
14 (II) A program to reduce taxable compensation or other
15 forms of compensation other than deferred compensation,
16 ➥ for the benefit of all state officers and employees and other
17 persons who participate in the Program.
18 (b) Ensure that the Program is funded on an actuarially sound
19 basis and operated in accordance with sound insurance and business
20 practices.
21 2. In establishing and carrying out the Program, the Board
22 shall:
23 (a) For the purpose of establishing actuarial data to determine
24 rates and coverage for active and retired state officers and
25 employees and their dependents, commingle the claims experience
26 of such active and retired officers and employees and their
27 dependents for whom the Program provides primary health
28 insurance coverage into a single risk pool.
29 (b) Except as otherwise provided in this paragraph, negotiate
30 and contract pursuant to paragraph (a) of subsection 1 of NRS
31 287.025 with the governing body of any county, school district,
32 municipal corporation, political subdivision, public corporation or
33 other local governmental agency of the State of Nevada that wishes
34 to obtain exclusive group insurance for all of its active and retired
35 officers and employees and their dependents, except as otherwise
36 provided in sub-subparagraph (III) of subparagraph (2) of paragraph
37 (h), by participation in the Program. The Board shall establish
38 separate rates and coverage for active and retired officers and
39 employees of those local governmental agencies and their
40 dependents based on actuarial reports that commingle the claims
41 experience of such active and retired officers and employees and
42 their dependents for whom the Program provides primary health
43 insurance coverage into a single risk pool.
44 (c) Except as otherwise provided in paragraph (d), provide
45 public notice in writing of any proposed changes in rates or

coverage to each participating public agency that may be affected by the changes. Notice must be provided at least 30 days before the effective date of the changes.

(d) If a proposed change is a change in the premium or contribution charged for, or coverage of, health insurance, provide written notice of the proposed change to all participants in the Program. The notice must be provided at least 30 days before the date on which a participant in the Program is required to select or change the participant's policy of health insurance.

(e) Purchase policies of life, accident or health insurance, or any combination of these, or, if applicable, a program to reduce the amount of taxable compensation pursuant to 26 U.S.C. § 125, from any company qualified to do business in this State or provide similar coverage through a plan of self-insurance established pursuant to NRS 287.0433 for the benefit of all eligible participants in the Program.

(f) Except as otherwise provided in this title, develop and establish other employee benefits as necessary.

(g) Investigate and approve or disapprove any contract proposed pursuant to NRS 287.0479.

(h) Adopt such regulations and perform such other duties as are necessary to carry out the provisions of NRS 287.010 to 287.245, inclusive, including, without limitation, the establishment of:

(1) Fees for applications for participation in the Program and for the late payment of premiums or contributions;

(2) Conditions for entry and reentry into and exit from the Program by local governmental agencies pursuant to paragraph (a) of subsection 1 of NRS 287.025, which:

(I) Must include a minimum period of 4 years of participation for entry into the Program;

(II) Must include a requirement that participation of any retired officers and employees of the local governmental agency whose last continuous period of enrollment with the Program began after November 30, 2008, terminates upon termination of the local governmental agency's contract with the Program; and

(III) May allow for the exclusion of active and retired officers and employees of the local governmental agency who are eligible for health coverage from a health and welfare plan or trust that arose out of collective bargaining under chapter 288 of NRS or a trust established pursuant to 29 U.S.C. § 186;

(3) Procedures by which a group of participants in the Program may leave the Program pursuant to NRS 287.0479 and conditions and procedures for reentry into the Program by those participants;

1 (4) Specific procedures for the determination of contested
2 claims;
3 (5) Procedures for review and notification of the termination
4 of coverage of persons pursuant to paragraph (b) of subsection 4 of
5 NRS 287.023; and
6 (6) Procedures for the payments that are required to be made
7 pursuant to paragraph (b) of subsection 4 of NRS 287.023.
8 3. The Board may use any services provided to state agencies
9 and shall use the services of the Purchasing Division of the
10 Department of Administration to establish and carry out the
11 Program.
12 4. The Board may engage the services of an attorney who
13 specializes in health plans and health care law as necessary to assist
14 in carrying out the Program.
15 5. The Board may make recommendations to the Legislature
16 concerning legislation that it deems necessary and appropriate
17 regarding the Program.
18 6. A participating public agency is not liable for any obligation
19 of the Program other than indemnification of the Board and its
20 employees against liability relating to the administration of the
21 Program, subject to the limitations specified in NRS 41.0349.
22 7. ***If the Board purchases or provides coverage for***
23 ***prescription drugs pursuant to paragraph (e) of subsection 2, such***
24 ***coverage must:***
25 ***(a) Use the formulary developed by the Department of Health***
26 ***and Human Services pursuant to subsection 1 of NRS 422.4025***
27 ***and provide for prescription drugs to be obtained through the***
28 ***purchasing agreements negotiated by the Department pursuant to***
29 ***that section; and***
30 ***(b) Allow a participant in the Program to credit any amount***
31 ***saved by using a coupon for a prescription drug toward any copay***
32 ***or coinsurance that the participant is required to pay for the***
33 ***prescription drug.***
34 ***8. If the Board purchases or provides health insurance***
35 ***pursuant to paragraph (e) of subsection 2, the Board may opt in to***
36 ***participate in a purchasing agreement negotiated by or pursuant***
37 ***to a contract with the Department under the provisions of***
38 ***subsection 2 of NRS 422.4025 for any goods or services by***
39 ***notifying the Department in the form prescribed by the***
40 ***Department.***
41 ***9.*** As used in this section, “employee benefits” includes any
42 form of compensation provided to a public employee except federal
43 benefits, wages earned, legal holidays, deferred compensation and
44 benefits available pursuant to chapter 286 of NRS.

Sec. 17. Chapter 679B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Department of Health and Human Services shall adopt regulations that:

(a) Prescribe or otherwise require each insurer that offers a health care plan in this State to participate in a system that rates each such health care plan on customer satisfaction and coverage for treatment and preventative care;

(b) Prescribe the manner in which an insurer is required to notify consumers of health care in this State of the rating of each health care plan offered by the insurer which must include, without limitation, posting the rating prominently on an Internet website operated by the insurer; and

(c) Are otherwise necessary or convenient to carry out the provisions of this section.

2. The Department of Health and Human Services may:

(a) Enter into a contract with a person or entity to establish and maintain the system described in paragraph (a) of subsection 1.

(b) Impose on an insurer a penalty of not more than $1,000 for each day the insurer fails to comply with the regulations adopted pursuant to this section.

3. The Department of Health and Human Services shall deposit the penalties collected pursuant to paragraph (b) of subsection 2 into a separate account in the State General Fund to be used to educate and advocate for consumers of health insurance.

Sec. 18. NRS 679B.510 is hereby amended to read as follows:

679B.510 As used in NRS 679B.510 to 679B.560, inclusive, ***and section 17 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 679B.520, 679B.530 and 679B.540 have the meanings ascribed to them in those sections.

Sec. 19. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A nonprofit health benefit plan that wishes to use the formulary developed by the Department of Health and Human Services pursuant to subsection 1 of NRS 422.4025 and obtain prescription drugs through the purchasing agreements negotiated by the Department pursuant to that section, or opt in to participate in purchasing agreements negotiated by or pursuant to a contract with the Department pursuant to subsection 2 of NRS 422.4025 for any other services, may do so by notifying the Department in the form prescribed by the Department.

2. A nonprofit health benefit plan that uses the formulary developed by the Department pursuant to subsection 1 of

1 ***NRS 422.4025 and obtains prescription drugs through the***
2 ***purchasing agreements negotiated by the Department pursuant to***
3 ***that subsection may cease doing so by notifying the Department in***
4 ***the form prescribed by the Department.***
5 ***3. As used in this section "health benefit plan" has the***
6 ***meaning ascribed to it in section 2 of this act.***
7 **Sec. 20.** NRS 689A.405 is hereby amended to read as follows:
8 689A.405 1. An insurer that offers or issues a policy of
9 health insurance which provides coverage for prescription drugs
10 shall include with any summary, certificate or evidence of that
11 coverage provided to an insured, notice of whether a formulary is
12 used and, if so, of the opportunity to secure information regarding
13 the formulary from the insurer pursuant to subsection 2. The notice
14 required by this subsection must:
15 (a) Be in a language that is easily understood and in a format
16 that is easy to understand;
17 (b) Include an explanation of what a formulary is; and
18 (c) If a formulary is used, include:
19 (1) An explanation of:
20 (I) How often the contents of the formulary are reviewed;
21 and
22 (II) The procedure and criteria for determining which
23 prescription drugs are included in and excluded from the formulary;
24 and
25 (2) The telephone number of the insurer for making a request
26 for information regarding the formulary pursuant to subsection 2.
27 2. If an insurer offers or issues a policy of health insurance
28 which provides coverage for prescription drugs and a formulary is
29 used, the insurer shall:
30 (a) Provide to any insured or participating provider of health
31 care, upon request:
32 (1) Information regarding whether a specific drug is included
33 in the formulary.
34 (2) Access to the most current list of prescription drugs in the
35 formulary, organized by major therapeutic category, with an
36 indication of whether any listed drugs are preferred over other listed
37 drugs. If more than one formulary is maintained, the insurer shall
38 notify the requester that a choice of formulary lists is available.
39 (b) Notify each person who requests information regarding the
40 formulary, that the inclusion of a drug in the formulary does not
41 guarantee that a provider of health care will prescribe that drug for a
42 particular medical condition.
43 (c) During each period for open enrollment, publish on an
44 Internet website that is operated by the insurer and accessible to the

public or include in any enrollment materials distributed by the insurer a notice of all prescription drugs that:

(1) Are included on the most recent list of drugs that are essential for treating diabetes in this State compiled by the Department of Health and Human Services pursuant to subsection 1 of NRS 439B.630; and

(2) Have been removed or will be removed from the formulary during the current plan year or the next plan year.

(d) Update the notice required by paragraph (c) throughout the period for open enrollment.

3. An insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 21. NRS 689B.0283 is hereby amended to read as follows:

689B.0283 1. An insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the insurer pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the insurer for making a request for information regarding the formulary pursuant to subsection 2.

2. If an insurer offers or issues a policy of group health insurance which provides coverage for prescription drugs and a formulary is used, the insurer shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an

indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the insurer shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. An insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 22. NRS 689C.281 is hereby amended to read as follows:

689C.281 1. A carrier that offers or issues a health benefit plan which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the carrier pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the carrier for making a request for information regarding the formulary pursuant to subsection 2.

2. If a carrier offers or issues a health benefit plan which provides coverage for prescription drugs and a formulary is used, the carrier shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the carrier shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A carrier that offers or issues a health benefit plan which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 23. NRS 689C.455 is hereby amended to read as follows:

689C.455 1. A carrier that offers or issues a contract which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the carrier pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the carrier for making a request for information regarding the formulary pursuant to subsection 2.

2. If a carrier offers or issues a contract which provides coverage for prescription drugs and a formulary is used, the carrier shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the carrier shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A carrier that offers or issues a contract which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 24. NRS 695A.255 is hereby amended to read as follows:

695A.255 1. A society that offers or issues a benefit contract which provides coverage for prescription drugs shall include with any certificate for such a contract provided to a benefit member, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the society pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the society for making a request for information regarding the formulary pursuant to subsection 2.

2. If a society offers or issues a benefit contract which provides coverage for prescription drugs and a formulary is used, the society shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the society shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A society that offers or issues a benefit contract which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug

toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 25. NRS 695B.176 is hereby amended to read as follows:

695B.176 1. An insurer that offers or issues a contract for hospital or medical services which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the insurer pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the insurer for making a request for information regarding the formulary pursuant to subsection 2.

2. If an insurer offers or issues a contract for hospital or medical services which provides coverage for prescription drugs and a formulary is used, the insurer shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the insurer shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. An insurer that offers or issues a contract for hospital or medical services which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

Sec. 26. NRS 695C.1703 is hereby amended to read as follows:

695C.1703 1. A health maintenance organization or insurer that offers or issues evidence of coverage which provides coverage for prescription drugs shall include with any evidence of that coverage provided to an enrollee, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization or insurer pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the organization or insurer for making a request for information regarding the formulary pursuant to subsection 2.

2. If a health maintenance organization or insurer offers or issues evidence of coverage which provides coverage for prescription drugs and a formulary is used, the organization or insurer shall:

(a) Provide to any enrollee or participating provider of health care upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the organization or insurer shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A health maintenance organization or insurer that offers or issues evidence of coverage which provides coverage for prescription drugs shall allow an enrollee to credit any amount saved by using a coupon for a prescription drug toward any copay

or coinsurance that the enrollee is required to pay for the prescription drug.

Sec. 27. NRS 695F.153 is hereby amended to read as follows:

695F.153 1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for prescription drugs shall include with any evidence of that coverage provided to a subscriber, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the organization for making a request for information regarding the formulary pursuant to subsection 2.

2. If a prepaid limited health service organization offers or issues evidence of coverage which provides coverage for prescription drugs and a formulary is used, the organization shall:

(a) Provide to any enrollee or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the organization shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for prescription drugs shall allow an enrollee to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the enrollee is required to pay for the prescription drug.

Sec. 28. NRS 695G.163 is hereby amended to read as follows:

695G.163 1. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the organization for making a request for information regarding the formulary pursuant to subsection 2.

2. If a managed care organization offers or issues a health care plan which provides coverage for prescription drugs and a formulary is used, the organization shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the organization shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

3. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall allow an insured to credit any amount saved by using a coupon for a prescription drug toward any copay or coinsurance that the insured is required to pay for the prescription drug.

4. A managed care organization that provides health care services 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:

(a) Shall use the formulary developed by the Department pursuant to subsection 1 of NRS 422.4025 and obtain prescription drugs through the purchasing agreements negotiated by the Department pursuant to that section; and

(b) May opt in to participate in a purchasing agreement negotiated by or pursuant to a contract with the Department pursuant to subsection 2 of NRS 422.4025 for any other goods or services by notifying the Department in the form prescribed by the Department.

Sec. 29. 1. Notwithstanding any other provision of law, the terms of the members appointed to the Pharmacy and Therapeutics Committee established pursuant to NRS 422.4035, as that section exists on December 31, 2019, expire on that date.

2. The Director of the Department of Health and Human Services may appoint to the Silver State Scripts Advisory Board established pursuant to NRS 422.4035, as amended by section 9 of this act, a person who served as a member of the Pharmacy and Therapeutics Committee established pursuant to NRS 422.4035, as that section exists on December 31, 2019.

Sec. 30. The amendatory provisions of sections 7, 15, 16 and 20-28 of this act do not apply to a contract entered into before January 1, 2020, to provide coverage for prescription drugs, but apply to any extension or renewal thereof.

Sec. 31. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 32. 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. 33. This act becomes effective:

1. 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

2. On January 1, 2020, for all other purposes.

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