Senate Bill No. 250–Senators Hardy, Smith, Roberson, Brower, Farley; Ford, Goicoechea, Gustavson, Harris, Kieckhefer and Lipparelli

Joint Sponsors: Assemblymen Oscarson and Titus

CHAPTER.....

AN ACT relating to insurance; requiring certain policies of health insurance and health care plans to provide coverage for certain prescriptions dispensed for a supply of less than 30 days; prohibiting certain policies of health insurance and health care plans from prorating any pharmacy dispensing fees for those prescriptions under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires certain public and private policies of insurance and health care plans to provide coverage for certain procedures, including colorectal cancer screenings, cytological screening tests and mammograms, in certain circumstances. (NRS 287.027, 287.04335, 689A.04042, 689A.0405, 689B.0367, 689B.0374, 695B.1907, 695B.1912, 695C.1731, 695C.1735, 695G.168) Existing law also requires employers to provide certain benefits to employees, including coverage for the procedures required to be covered by insurers, if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 1, 3, 4, 6, 7, 10 and 11** of this bill require that certain public and private policies of insurance and health care plans must authorize certain prescriptions to be divided into more than one dispensing for the purpose of synchronizing a patient's multiple prescriptions. **Sections 1, 3, 4, 6, 7, 10 and 11** prohibit these policies and plans from denying a claim for such a prescription that is otherwise covered. Finally, **sections 1, 3, 4, 6, 7, 10 and 11** prohibit these policies and plans from prorating the pharmacy dispensing fees for such prescriptions unless otherwise provided by a contract or other agreement.

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

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer who offers or issues a policy of health insurance which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the insurer.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. A policy subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 2. 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 1 of this act.***

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer who offers or issues a policy of group health insurance which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the insurer.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. A policy subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 4. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A carrier who offers or issues a health benefit plan which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the carrier.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. A health benefit plan subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the health benefit plan or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 5. 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 4 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. 6. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A hospital or medical services corporation who offers or issues a policy of health insurance which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the hospital or medical services corporation.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. A policy of health insurance subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy of health insurance or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the

purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 7. 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 which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the enrollee's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the enrollee; and

(2) The enrollee requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the health maintenance organization.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 8. 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 to 695C.173, inclusive, 695C.1733 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, 695C.1695 and 695C.1731 ***and section 7 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. 9. 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, ***and section 7 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;

(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. 10. 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 which provides coverage for prescription drugs:

(a) Must authorize coverage for and may apply a copayment and deductible to a prescription that is dispensed by a pharmacy for less than a 30-day supply if, for the purpose of synchronizing the insured's chronic medications:

(1) The prescriber or pharmacist determines that filling or refilling the prescription in that manner is in the best interest of the insured; and

(2) The insured requests less than a 30-day supply.

(b) May not deny coverage for a prescription described in paragraph (a) which is otherwise approved for coverage by the managed care organization.

(c) Unless otherwise provided by a contract or other agreement, may not prorate any pharmacy dispensing fees for a prescription described in paragraph (a).

2. An evidence of coverage subject to the provisions of this chapter which provides coverage for prescription drugs and that is delivered, issued for delivery or renewed on or after January 1, 2017, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.

3. The provisions of this section do not apply to unit-of-use packaging for which synchronization is not practicable or to a controlled substance.

4. As used in this section:

(a) "Chronic medication" means any drug that is prescribed to treat any disease or other condition which is determined to be permanent, persistent or lasting indefinitely.

(b) "Synchronization" means the alignment of the dispensing of multiple medications by a single contracted pharmacy for the purpose of improving a patient's adherence to a prescribed course of medication.

(c) "Unit-of-use packaging" means medication that is prepackaged by the manufacturer in blister packs, compliance packs, course-of-therapy packs or any other packaging which is designed and intended to be dispensed directly to the patient without modification by the dispensing pharmacy, except for the addition of a prescription label.

Sec. 11. 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 3 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph.

(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. 12. 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 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.167, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 10 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. 13. 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. 14. This act becomes effective:

1. Upon passage and approval for the purposes of adopting any regulations and performing any preparatory administrative tasks necessary to carry out the provisions of this act; and

2. On January 1, 2017, for all other purposes.