SENATE BILL NO. 378–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF THE COMMITTEE TO CONDUCT AN INTERIM STUDY CONCERNING THE COSTS OF PRESCRIPTION DRUGS)

MARCH 26, 2021

Referred to Committee on Health and Human Services

SUMMARY—Imposes certain requirements relating to insurance coverage of prescription drugs. (BDR 57-442)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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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 insurance; requiring certain insurers that provide coverage for prescription drugs to include in half of the plans that provide such coverage certain limitations on costs to an insured for prescription drugs; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes requirements concerning the coverage that must be provided by various plans of health insurance. (NRS 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194-689C.195, 695B.1901-695B.1948, 695C.1691-695C.176, 695G.162-695G.177) **Sections 1, 3, 4, 6, 7 and 10** of this bill require at least half of the health plans offered for sale in this State by private sector health insurers regulated under state law that include coverage for prescription drugs to: (1) provide such coverage with no deductible and a fixed copayment; and (2) limit the total amount of the copayments that an insured may be required to pay for prescription drugs in a year to a prescribed amount. **Sections 2 and 5** of this bill make conforming changes to indicate the placement of **sections 1 and 4** of this bill in the Nevada Revised Statutes. **Sections 8 and 11** of this bill exempt a health maintenance organization that provides health care services to recipients of Medicaid from the requirements of **sections 7 and 10** of this bill. **Section 9** 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 7** of this bill. The Commissioner would

also be authorized to take such action against a health insurer who fails to comply with the requirements of **section 1, 3, 4, 6 or 10** 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 689A of NRS is hereby amended by adding thereto a new section to read as follows:

At least half of the policies of insurance offered by an insurer for sale in this State that provide coverage for prescription drugs:

1. Must not require the insured to pay a deductible for coverage of prescription drugs, beginning on the day on which the insured is first enrolled in the policy;

2. Must establish a copayment for each prescription drug covered by the policy in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an insured pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the insured may be required to pay for services covered under the policy during that year.

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:

At least half of the policies of group health insurance offered by an insurer for sale in this State that provide coverage for prescription drugs:

1. Must not require the insured to pay a deductible for coverage of prescription drugs, beginning on the day on which the insured is first enrolled in the policy;

2. Must establish a copayment for each prescription drug covered by the policy in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an insured pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the insured may be

required to pay for services covered under the policy during that year.

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

At least half of the health benefit plans offered by a carrier for sale in this State that provide coverage for prescription drugs:

1. Must not require the insured to pay a deductible for coverage of prescription drugs, beginning on the day on which the insured is first enrolled in the plan;

2. Must establish a copayment for each prescription drug covered by the plan in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an insured pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the insured may be required to pay for services covered under the plan during that year.

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:

At least half of the policies of health insurance offered by a hospital or medical services corporation for sale in this State that provide coverage for prescription drugs:

1. Must not require the insured to pay a deductible for coverage of prescription drugs, beginning on the day on which the insured is first enrolled in the policy;

2. Must establish a copayment for each prescription drug covered by the policy in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an insured pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the insured may be required to pay for services covered under the policy during that year.

Sec. 7. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

At least half of the health care plans offered by a health maintenance organization for sale in this State that provide coverage for prescription drugs:

1. Must not require the enrollee to pay a deductible for coverage of prescription drugs, beginning on the day on which the enrollee is first enrolled in the plan;

2. Must establish a copayment for each prescription drug covered by the plan in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an enrollee pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the enrollee may be required to pay for services covered under the plan during that year.

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, 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 ***and section 7 of this act*** 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 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 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. 10. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

At least half of the health care plans offered by a managed care organization for sale in this State that provide coverage for prescription drugs:

1. Must not require the insured to pay a deductible for coverage of prescription drugs, beginning on the day on which the insured is first enrolled in the plan;

2. Must establish a copayment for each prescription drug covered by the plan in a fixed dollar amount that is not based on a percentage of the total cost of the prescription drug; and

3. Must limit the total amount of the copayments that an insured pays for prescription drugs in a year to not more than one-twelfth of the maximum total amount that the insured may be required to pay for services covered under the plan during that year.

Sec. 11. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal

benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.164, 695G.1645, 695G.167, 695G.200 to 695G.230, inclusive, and 695G.430 ***and section 10 of this act*** do not apply to 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. This subsection does not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 12. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

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