REQUIRES TWO-THIRDS MAJORITY VOTE
(§§ 11, 16, 17)

S.B. 392

SENATE BILL NO. 392–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—Revises provisions relating to pharmacy benefit managers. (BDR 40-446)

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

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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 pharmacy benefit managers; requiring pharmacy benefit managers to obtain a license from the Department of Health and Human Services; authorizing the Department to take certain actions to regulate pharmacy benefit managers; enacting certain requirements concerning the operation of a pharmacy benefit manager; requiring pharmacy benefit managers to report information relating to certain coverage regulated under federal law; removing the requirement that a pharmacy benefit manager obtain from the Commissioner of Insurance a certificate of registration as an administrator; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law: (1) defines the term "pharmacy benefit manager" to mean an entity that contracts with or is employed by a third-party insurer and manages the pharmacy benefits plan provided by the third-party insurer; and (2) requires a person who administers certain types of insurance, including a pharmacy benefit manager, to obtain a certificate of registration as an administrator from the Commissioner of Insurance. (NRS 683A.025, 683A.085, 683A.174) **Section 62** of this bill removes the requirement that a pharmacy benefit manager be certified as an administrator, and **section 12** of this bill instead requires a pharmacy benefit

manager to obtain a license from the Department of Health and Human Services. **Sections 2-9** of this bill define certain terms related to pharmacy benefit managers. **Section 10** of this bill authorizes the Department to conduct examinations of pharmacy benefit managers and hold hearings and issue subpoenas to carry out the provisions of **sections 2-35** of this bill. **Section 11** of this bill authorizes the Department to adopt regulations governing pharmacy benefit managers.

Sections 12-22 and 25-35 of this bill enact provisions concerning the licensure and regulation of pharmacy benefit managers that prescribe requirements similar to those prescribed by existing law governing administrators. Specifically, **sections 13 and 14** of this bill prescribe requirements to apply for a license as a pharmacy benefit manager. **Section 15** of this bill requires the Department to take certain action to ensure the collection of child support from a debtor who is licensed as a pharmacy benefit manager. **Sections 16-18** of this bill prescribe requirements governing the issuance and renewal of a license as a pharmacy benefit manager. **Section 19** of this bill requires a pharmacy benefit manager to annually submit to the Department a report that contains certain financial information. **Section 20** of this bill requires a pharmacy benefit manager to file a surety bond with the Department. **Section 21** of this bill prescribes requirements governing an agreement between a pharmacy benefit manager and a third-party insurer for which the pharmacy benefit manager provides services. **Section 22** of this bill sets forth when certain payments between covered persons, a pharmacy benefit manager and a third-party are deemed to have been received.

Existing law: (1) imposes upon a pharmacy benefit manager a duty of good faith and fair dealing toward a third-party insurer or pharmacy when performing duties pursuant to a contract; and (2) prohibits a pharmacy benefit manager from taking certain actions against a pharmacy or pharmacist. (NRS 683A.178, 683A.179) **Section 68** of this bill repeals those provisions in chapter 683A of NRS, which is under the jurisdiction of the Commissioner. **Sections 23 and 24** of this bill enact similar provisions in chapter 439B of NRS, which is under the jurisdiction of the Department, except that **section 23** imposes upon a pharmacy benefit manager a fiduciary duty toward a third-party insurer rather than a duty of good faith and fair dealing. **Section 25** of this bill authorizes a pharmacy benefit manager to advertise a pharmacy benefits plan only with the approval of the third-party insurer with which the pharmacy benefit manager has contracted to manage the plan. **Section 26** of this bill: (1) requires a pharmacy benefit manager to maintain certain books and records; and (2) authorizes a third-party insurer with which the pharmacy benefit manager has contracted to audit those books and records.

Section 27 of this bill imposes requirements governing the holding and payment of money by a pharmacy benefit manager. **Sections 28 and 29** of this bill prescribes procedures concerning the approval, denial and payment of claims by a pharmacy benefit manager. **Section 30** of this bill prohibits a pharmacy benefit manager form deriving income from the management of a pharmacy benefits plan in this State except for income derived from administrative fees paid by the third-party insurer that underwrites the plan. **Section 30** also imposes requirements concerning those fees and the disposal of income generated through discounts, pricing incentives, fees or rebates paid by a manufacturer. **Sections 37 and 44** of this bill remove conflicting or unnecessary provisions concerning pharmacy benefit managers who manage pharmacy benefits for the Medicaid program. **Sections 31 and 32** of this bill impose certain requirements concerning communications between pharmacy benefit managers, third-party insurers and covered persons. **Section 33** of this bill prohibits a pharmacy benefit manager from engaging in certain conduct while managing pharmacy benefits under an individual or small group health plan because of the health status, claims experience, industry, occupation or geographic location of a natural person, family or small employer. **Section 34** of this bill prescribes grounds for imposing disciplinary action against a

pharmacy benefit manager. **Section 35** of this bill additionally: (1) authorizes the imposition of an administrative fine against an unlicensed person who acts as a pharmacy benefit manager; and (2) makes it a misdemeanor to violate any provision of **sections 2-35**. **Sections 36, 38-43, 45-61 and 63-67** of this bill make conforming changes to ensure that the treatment of pharmacy benefit managers under other areas of law does not change as a result of the changes made by this bill.

Existing law provides that pharmacy benefit managers are not required to report information relating to prescription drug coverage that is a part of a plan regulated under the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., but that such a plan may require a pharmacy benefit manager to report that information by contract. (NRS 439B.645) In *Rutledge v. Pharm. Care Mgmt. Ass'n*, the United States Supreme Court held that states are authorized to impose general requirements governing pharmacy benefit managers on pharmacy benefit managers that manage such coverage. 141 S.Ct. 474, 481 (2020) **Section 37** of this bill removes the exemption for such coverage from requirements for the reporting of information by pharmacy benefit managers, thereby requiring a pharmacy benefit manager to report information relating to such coverage regardless of whether they are required to do so by contract.

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

Section 1. Title 40 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 35, inclusive, of this act.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 2 to 9, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Covered person" means a person who is covered by a pharmacy benefits plan.***

Sec. 4. ***"Department" means the Department of Health and Human Services.***

Sec. 5. ***"Pharmacy" has the meaning ascribed to it in NRS 639.012.***

Sec. 6. ***"Pharmacy benefit manager" means an entity that contracts with or is employed by a third-party and manages the pharmacy benefits plan provided by the third-party.***

Sec. 7. ***"Pharmacy benefits plan" means coverage of prescription drugs provided by a third-party.***

Sec. 8. ***"State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands or any territory or insular possession subject to the jurisdiction of the United States.***

Sec. 9. ***"Third party" means:***

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides a pharmacy benefits plan;

3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

4. Any other insurer or organization that provides health coverage or benefits or coverage of prescription drugs as part of workers' compensation insurance in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 10. ***The Department may:***

1. Conduct any examination of an applicant for the issuance of a license as a pharmacy benefit manager or the holder of such a license as the Department finds necessary to carry out the provisions of this chapter and the regulations adopted pursuant thereto. The examination may include, without limitation, an audit or inspection of any books or records maintained by the pharmacy benefit manager.

2. Hold hearings and issue subpoenas requiring the attendance of witnesses and the production of evidence as the Department finds necessary to carry out the provisions of this chapter and the regulations adopted pursuant thereto.

Sec. 11. ***1. The Department shall adopt any regulations necessary to carry out the provisions of this chapter. The regulations must prescribe:***

(a) Fees for the issuance and renewal of a license as a pharmacy benefit manager. The Department shall use the income generated from the fees prescribed pursuant to this paragraph to administer the provisions of this chapter and NRS 439B.600 to 439B.695, inclusive.

(b) Procedures for conducting examinations and hearings pursuant to this chapter.

2. The Department may waive any requirement which the Department has promulgated pursuant to this section for the issuance or renewal of a license as a pharmacy benefit manager, except for the fee for the issuance or renewal of the license, to any person or class of persons. In so doing the Department shall consider, without limitation:

(a) Whether the person acting as a pharmacy benefit manager is primarily involved in a business other than that of pharmacy benefit manager.

(b) Whether the financial strength and history of the organization to which the applicant belongs, or which is the applicant, indicates stability in its continuity of doing business.

(c) Whether the regular duties being performed by the pharmacy benefit manager are such that the recipients of pharmacy benefits managed by the pharmacy benefit manager are not likely to be injured by a waiver of requirements.

Sec. 12. *No person may act as, offer to act as or hold himself or herself out to the public as a pharmacy benefit manager, unless:*

1. The person has obtained a license from the Department pursuant to section 13 of this act;

2. If the person is a natural person and adjusts workers' compensation claims in this State, the person is licensed pursuant to chapter 684A of NRS; and

3. If any employee of the person adjusts workers' compensation claims in this State, each such employee who adjusts workers' compensation claims in this State is licensed pursuant to chapter 684A of NRS.

Sec. 13. *A person who wishes to obtain a license as a pharmacy benefit manager must submit an application to the Department in the form prescribed by the Department. The application must include or be accompanied by:*

1. A financial statement of the applicant that has been reviewed by an independent certified public accountant and which includes:

(a) A statement regarding the amount of money that the applicant expects to collect from or disburse to residents of this State during the next calendar year.

(b) Financial information for the 90 days immediately preceding the date the application was filed with the Department.

(c) An income statement and balance sheet for the 2 years immediately preceding the application that are:

(1) Prepared in accordance with generally accepted accounting principles; and

(2) Reviewed by an independent certified public accountant.

(d) A certification of the financial statement by an officer of the applicant.

2. The documents used to create the business association of the pharmacy benefit manager, including, without limitation, articles of incorporation, articles of association, a partnership agreement, a trust agreement and a shareholders' agreement.

3. The documents used to regulate the internal affairs of the pharmacy benefit manager, including, without limitation, the bylaws, rules or regulations of the pharmacy benefit manager.

4. A certificate of registration issued pursuant to NRS 600.350 for a trade name or trademark used by the pharmacy benefit manager, if applicable.

5. An organizational chart that identifies each person who directly or indirectly controls the pharmacy benefit manager and each affiliate of the pharmacy benefit manager.

6. A notarized affidavit from each person who manages or controls the pharmacy benefit manager, including, without limitation, each member of the board of directors or board of trustees, each officer, partner and member of the business association of the pharmacy benefit manager and each shareholder of the pharmacy benefit manager who holds not less than 10 percent of the voting stock of the pharmacy benefit manager. The affidavit must include:

(a) The personal history, business record and insurance experience of the affiant;

(b) Whether the affiant has been investigated by any regulatory authority or has had any license, certificate or other credential denied, suspended or revoked in any state; and

(c) Any other information that the Department may require.

7. The complete name and address of each office of the pharmacy benefit manager, including, without limitation, offices located outside this State.

8. A statement that sets forth whether the pharmacy benefit manager has:

(a) Held a license, certificate or other credential as a pharmacy benefit manager or to transact insurance in this State or any other state and whether that license, certificate or other credential has been refused, suspended or revoked;

(b) Been indebted to any person and, if so, the circumstances of that debt; and

(c) Had an administrative agreement cancelled and, if so, the circumstances of that cancellation.

9. A statement that describes the business plan of the pharmacy benefit manager. The statement must include information:

(a) Concerning the number of persons on the staff of the pharmacy benefit manager and the activities proposed in this State or any other state.

(b) That demonstrates the capability of the pharmacy benefit manager to provide a sufficient number of experienced and

qualified persons for the processing of claims, the keeping of records and, if applicable, underwriting.

10. If the applicant intends to solicit new or renewal business, proof that the applicant employs or has contracted with a producer of insurance licensed in this State to solicit and take applications. An applicant who intends to solicit insurance contracts directly or to act as a producer must provide proof that the applicant is licensed as a producer in this State.

Sec. 14. *1 In addition to any other requirements set forth in this chapter, a natural person who applies for the issuance or renewal of a license as a pharmacy benefit manager pursuant to section 13 of this act shall:*

(a) Include the social security number of the applicant in the application submitted to the Department.

(b) Submit to the Department the statement prescribed by the Division of Welfare and Supportive Services of the Department pursuant to NRS 425.520. The statement must be completed and signed by the applicant.

2. The Department shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the license; or

(b) A separate form prescribed by the Department.

3. A license may not be issued or renewed by the Department if an applicant who is a natural person:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant who is a natural person indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Department shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

Sec. 15. *1. If the Department receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational*

licenses, certificates and permits issued to a natural person who is the holder of a license as a pharmacy benefit manager, the Department shall deem the license issued to that natural person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Department receives a letter issued to the holder of the license by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the license has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

2. The Department shall reinstate a license that has been suspended by a district court pursuant to NRS 425.540 if the Department receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the natural person whose license was suspended stating that the natural person whose license was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

Sec. 16. *1. Except as otherwise provided in subsection 2 or 3 and section 14 of this act, the Department shall issue a license as a pharmacy benefit manager to an applicant who:*

(a) Submits an application that meets the requirements of section 13 of this act and, if applicable, complies with the requirements of section 14 of this act; and

(b) Pays the fee for the issuance of a certificate of registration prescribed by the regulations adopted pursuant to section 11 of this act.

2. The Department may refuse to issue a license as a pharmacy benefit manager to an applicant if the Department determines that the applicant or any person who has completed an affidavit pursuant to subsection 6 of section 13 of this act:

(a) Is not competent to act as a pharmacy benefit manager or manage or control a pharmacy benefit manager, as applicable;

(b) Is not trustworthy or financially responsible;

(c) Does not have a good personal or business reputation;

(d) Has had a license, certificate or other credential as a pharmacy benefit manager or to transact insurance denied for cause, suspended or revoked in this State or any other state;

(e) Has failed to comply with any provision of this chapter or committed any act which is grounds for disciplinary action pursuant to section 34 of this act; or

(f) Is financially unsound.

3. If an applicant seeks final approval by the Division of Industrial Relations of the Department of Business and Industry in accordance with regulations adopted pursuant to subsection 8 of NRS 616A.400, the Department of Health and Human Services must submit to the Division the information supplied by the

applicant pursuant to subsection 1. Unless the Division provides final approval for the applicant to the Department of Health and Human Services, the Department of Health and Human Services shall not issue a license as a pharmacy benefit manager to the applicant.

Sec. 17. *1. A license as a pharmacy benefit manager is valid for 3 years after the date the Department issues the license.*

2. Except as otherwise provided in sections 14 and 18 of this act, a pharmacy benefit manager may renew a license if the pharmacy benefit manager:

(a) Submits to the Department an application on a form prescribed by the Department and the fee for the renewal of the license prescribed by the regulations adopted pursuant to section 11 of this act; and

(b) If applicable, complies with the requirements of section 14 of this act.

Sec. 18. *1. In addition to any other requirements set forth in this chapter, an applicant for the renewal of a license as a pharmacy benefit manager must indicate in the application submitted to the Department whether the applicant has a state business license. If the applicant has a state business license, the applicant must include in the application the business identification number assigned by the Secretary of State upon compliance with the provisions of chapter 76 of NRS.*

2. The Department must not renew a license as a pharmacy benefit manager if:

(a) The applicant fails to submit the information required by subsection 1; or

(b) The State Controller has informed the Department pursuant to subsection 5 of NRS 353C.1965 that the applicant owes a debt to an agency that has been assigned to the State Controller for collection and the applicant has not:

(1) Satisfied the debt;

(2) Entered into an agreement for the payment of the debt pursuant to NRS 353C.130; or

(3) Demonstrated that the debt is not valid.

3. As used in this section:

(a) "Agency" has the meaning ascribed to it in NRS 353C.020.

(b) "Debt" has the meaning ascribed to it in NRS 353C.040.

Sec. 19. *1. Not later than 90 days after the expiration of the fiscal year of the pharmacy benefit manager, or within such other period as the Department may allow, the holder of a certificate of a license as a pharmacy benefit manager shall file with the Department an annual report for that fiscal year. Each annual report must be verified by at least two officers of the pharmacy*

benefit manager or, if the pharmacy benefit manager does not have two officers, at least one natural person responsible for the operation of the pharmacy benefit manager.

2. Each annual report filed pursuant to this section must include all of the following:

(a) A financial statement of the pharmacy benefit manager that has been reviewed by an independent certified public accountant.

(b) The complete name and address of each third party, if any, for whom the pharmacy benefit manager agreed to act as a pharmacy benefit manager during the fiscal year.

(c) A statement regarding the total money handled by the pharmacy benefit manager on behalf of contracted third parties in connection with his or her activities as a pharmacy benefit manager. The statement must be on a form prescribed or approved by the Department for the purpose of calculating the amount of the bond required by section 20 of this act.

(d) Any other information required by the Department.

3. Except as otherwise provided in subsection 4, in addition to the information required pursuant to subsection 2, if an annual report is prepared on a consolidated basis, the annual report must include supplemental exhibits that:

(a) Have been reviewed by an independent certified public accountant; and

(b) Include a balance sheet and income statement for the licensee.

4. In lieu of complying with the requirements set forth in paragraphs (a) and (b) of subsection 3, a pharmacy benefit manager who is a wholly owned subsidiary of a parent company may submit to the Department:

(a) The financial statement of the parent company that has been audited by an independent certified public accountant; and

(b) A parental guaranty that is signed by an officer of the parent company and which guarantees the financial solvency of the pharmacy benefit manager.

5. The Department shall, for each pharmacy benefit manager, review the annual report that is most recently filed by the pharmacy benefit manager. As soon as practicable after reviewing the report, the Department shall issue a certificate to the pharmacy benefit manager indicating that, based on the annual report and accompanying financial statement, the pharmacy benefit manager is currently licensed and in good standing in this State.

Sec. 20. *1. Each pharmacy benefit manager shall file with the Department a bond with an authorized surety in favor of the*

State of Nevada, continuous in form and in an amount determined by the Department of not less than $100,000.

2. The Department shall establish schedules for the amount of the bond required, based on the amount of money received and distributed by a pharmacy benefit manager.

3. The bond must inure to the benefit of any person damaged by any fraudulent act or conduct of the pharmacy benefit manager and must be conditioned upon faithful accounting and application of all money coming into the possession of the pharmacy benefit manager in connection with his or her activities as a pharmacy benefit manager.

4. The bond remains in force until released by the Department or cancelled by the surety. Without prejudice to any liability previously incurred, the surety may cancel the bond upon 90 days' advance notice to the pharmacy benefit manager and the Department. A license as a pharmacy benefit manager is automatically suspended if the pharmacy benefit manager does not file with the Department a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this section for the initial bond.

Sec. 21. *1. No person may act as a pharmacy benefit manager unless the person has entered into a written agreement with a third party and the written agreement contains provisions to effectuate the requirements contained in sections 22 to 33, inclusive, of this act which apply to the duties of the pharmacy benefit manager.*

2. The written agreement must:

(a) Set forth the duties the pharmacy benefit manager will be required to perform on behalf of the third party; and

(b) Be fully transparent concerning the terms of the agreement, including, without limitation, full disclosure of all rebates, discounts, pricing incentives and fees collected by the pharmacy benefit manager from administering pharmacy benefits under the agreement.

3. A pharmacy benefit manager shall retain a copy of an agreement entered into under the provisions of this section in the records of the pharmacy benefit manager for a period of 5 years after the termination of the agreement.

4. The Department may adopt regulations which specify the functions a pharmacy benefit manager may perform on behalf of a third party.

5. The third party or pharmacy benefit manager may, upon written notice to the other party to the agreement and to the Department, terminate the written agreement for any cause specified in the agreement. The third party may suspend the

authority of the pharmacy benefit manager while any dispute regarding the cause for termination is pending. The third party shall perform any obligations with respect to the policies affected by the agreement regardless of any dispute with the pharmacy benefit manager.

Sec. 22. *1. Payment by or on behalf of a covered person to a pharmacy benefit manager shall be deemed to have been received by the third party.*

2. Payment to the pharmacy benefit manager by the third party of return premiums or claim settlements shall not be deemed to be payment to the covered person or claimant until the money is received by the covered person or claimant.

3. This section does not limit any right of the third party against the pharmacy benefit manager resulting from a failure to make payments to a third party, covered person or claimant.

Sec. 23. *1. A pharmacy benefit manager has:*

(a) A fiduciary duty to a third party with which the pharmacy benefit manager has entered into an agreement to manage the pharmacy benefits plan of the third party; and

(b) A duty of good faith and fair dealing toward a pharmacy when performing duties pursuant to an agreement to which the pharmacy benefit manager is a party.

2. A pharmacy benefit manager:

(a) Shall notify a third party or pharmacy in writing of any activity, policy or practice of the pharmacy benefit manager that presents a conflict of interest that interferes with the ability of the pharmacy benefit manager to discharge any duty imposed by subsection 1; and

(b) Shall not engage in any activity or implement any policy or practice that the pharmacy benefit manager reasonably anticipates will present a conflict of interest that interferes with the ability of the pharmacy benefit manager to discharge any duty imposed by subsection 1.

3. Any provision of a contract that waives or limits any duty imposed by this section is against public policy, void and unenforceable.

Sec. 24. *1. A pharmacy benefit manager shall not:*

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

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

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

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

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

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

2. The provisions of this section:

(a) Must not be construed to authorize a pharmacist to dispense a drug that has not been prescribed by a practitioner, as defined in NRS 639.0125.

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

3. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

Sec. 25. *A pharmacy benefit manager may advertise the pharmacy benefits plan which he or she manages only after the pharmacy benefit manager receives the approval of the third party with which the pharmacy benefit manager has entered into an agreement to manage the pharmacy benefits plan.*

Sec. 26. *1. Each pharmacy benefit manager shall maintain at his or her principal office adequate books and records of all transactions between the pharmacy benefit manager, the third party and the covered persons. The books and records must be maintained in accordance with prudent standards of recordkeeping for pharmacy benefit managers and with regulations of the Department for a period of 5 years after the transaction to which they respectively relate. After the 5-year period, the pharmacy benefit manager may remove the books and records from this State, store their contents on microfilm or return them to the appropriate third party.*

2. The names and addresses of covered persons and any other material which is in the books and records of a pharmacy benefit manager are confidential except as otherwise provided in NRS

239.0115 and except when used in proceedings against the pharmacy benefit manager.

3. A third party with which a pharmacy benefit manager has entered into an agreement may audit all books and records of the pharmacy benefit manager to the extent necessary to fulfill all contractual obligations to covered persons and ensure compliance with the provisions of the agreement, this chapter and the regulations adopted pursuant thereto. Such an audit may include, without limitation, an examination of claims for pharmacy benefits, rebates and any other information necessary to accomplish the purposes set forth in this subsection.

Sec. 27. *1. All insurance charges and premiums collected by a pharmacy benefit manager on behalf of a third party and return premiums received from a third party are held by the pharmacy benefit manager in a fiduciary capacity.*

2. Money must be remitted within 15 days to the person or persons entitled to it, or be deposited within 15 days in one or more fiduciary accounts established and maintained by the pharmacy benefit manager in a bank, credit union or other financial institution in this State. The fiduciary accounts must be separate from the personal or business accounts of the pharmacy benefit manager.

3. If charges or premiums deposited in an account have been collected for or on behalf of more than one third party, the pharmacy benefit manager must cause the bank, credit union or other financial institution where the fiduciary account is maintained to record clearly the deposits and withdrawals from the account on behalf of each third party.

4. The pharmacy benefit manager shall promptly obtain and keep copies of the records of each fiduciary account and shall furnish any third party with copies of the records which pertain to him or her upon demand of the third party.

5. The pharmacy benefit manager shall not pay any claim by withdrawing money from his or her fiduciary account in which premiums or charges are deposited.

6. Withdrawals must be made as provided in the agreement between the third party and the pharmacy benefit manager for:

(a) Remittance to the third party.

(b) Deposit in an account maintained in the name of the third party.

(c) Transfer to and deposit in an account for the payment of claims.

(d) Payment to a group policyholder for remittance to the third party entitled to the money.

(e) Payment to the pharmacy benefit manager of the fees of the pharmacy benefit manager.

(f) Remittance of return premiums to persons entitled to them.

7. The pharmacy benefit manager shall maintain copies of all records relating to deposits or withdrawals and, upon the request of a third party, provide the third party with copies of those records.

Sec. 28. ***1. Except as otherwise provided in subsection 2, a pharmacy benefit manager shall approve or deny a claim within 30 days after the pharmacy benefit manager receives the claim. If the claim is approved, the pharmacy benefit manager shall pay the claim within 30 days after it is approved. Except as otherwise provided in subsection 2, if the approved claim is not paid within that period, the pharmacy benefit manager shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.***

2. If the pharmacy benefit manager requires additional information to determine whether to approve or deny the claim, the pharmacy benefit manager must notify the claimant of the pharmacy benefit manager's request for the additional information within 20 days after receiving the claim. The pharmacy benefit manager shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the pharmacy benefit manager must pay the claim within 30 days after receiving the additional information. If the approved claim is not paid within that period, the pharmacy benefit manager must pay interest on the claim in the manner prescribed in subsection 1.

3. A pharmacy benefit manager shall not request a claimant to resubmit information that the claimant has already provided to the pharmacy benefit manager unless the pharmacy benefit manager provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A pharmacy benefit manager shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the

payment was delayed because of an act of God or another cause beyond the control of the pharmacy benefit manager.

7. The Department may require a pharmacy benefit manager to provide evidence which demonstrates that the pharmacy benefit manager has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Department determines that a pharmacy benefit manager is not in substantial compliance with the requirements set forth in this section, the Department may require the pharmacy benefit manager to pay an administrative fine in an amount to be determined by the Department. Upon a second or subsequent determination that a pharmacy benefit manager is not in substantial compliance with the requirements set forth in this section, the Department may suspend or revoke the license of the pharmacy benefit manager.

Sec. 29. *Each claim paid by a pharmacy benefit manager from money collected for or on behalf of a third party must be paid by a check or draft upon and as authorized by the third party.*

Sec. 30. *1. A pharmacy benefit manager shall not derive income from the management of a pharmacy benefits plan in this State except for income derived from administrative fees paid by the third party with which the pharmacy benefit manager has entered into an agreement to manage the pharmacy benefits plan. Such administrative fees must be set forth in the agreement between the pharmacy benefit manager and the third party. The amount of those fees may be based upon premiums or charges collected, on the number of claims paid or processed or on any other basis agreed upon by the pharmacy benefit manager and the third party, except as provided in this section.*

2. Fees paid to a pharmacy benefit manager may not be based upon or contingent upon:

(a) The claim experience of the policies that he or she handles; or

(b) The savings realized by the pharmacy benefit manager by adjusting, settling or paying the losses covered by a third party.

3. A pharmacy benefit manager shall provide:

(a) Any income generated through discounts offered by a manufacturer of prescription drugs or pricing incentives or fees collected from a manufacturer to the third party; and

(b) Any income generated through rebates paid by a manufacturer of prescription drugs to covered persons.

Sec. 31. *1. A pharmacy benefit manager shall advise each covered person, by means of a written notice approved by the third*

party, of the identity of and relationship among the third party, pharmacy benefit manager and covered person.

2. A pharmacy benefit manager who seeks to collect premiums or charges shall clearly set forth in writing to the covered person the amount of premium or charge set by the third party for the insurance coverage and the reason for the collection of the premium or charge. Each charge must be set forth separately from the premium.

Sec. 32. *A pharmacy benefit manager shall deliver or cause to be delivered to covered persons any written communications of a third party on whose behalf the pharmacy benefit manager manages a pharmacy benefits plan which are given to the pharmacy benefit manager for delivery.*

Sec. 33. *1. Except as otherwise provided in this section, a pharmacy benefit manager that enters into a contract, agreement or other arrangement with a third party to manage a pharmacy benefits plan that is part of coverage provided under the provisions of chapter 689A or 689C of NRS shall not, directly or indirectly:*

(a) Encourage or direct a natural person, family or small employer to refrain from filing an application for coverage with the third party because of the health status, claims experience, industry, occupation or geographic location of the natural person, family or small employer, as applicable.

(b) Encourage or direct a natural person, family or small employer to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the person, family or small employer, as applicable.

2. The provisions of subsection 1 do not apply to information provided to a natural person, family or small employer by a third party relating to the geographic service area or a provision for a restricted network of the third party.

3. A pharmacy benefit manager shall not, directly or indirectly, enter into any contract, agreement or arrangement with a third party if the contract, agreement or arrangement provides for or results in a variation to the compensation paid to a third party for the sale of a pharmacy benefits plan regulated under the provisions of chapter 689A or 689C of NRS because of the health status, claims experience, industry, occupation or geographic location of the natural person, family or small employer at the time that the pharmacy benefits plan is issued to or renewed by the natural person, family or small employer, as applicable.

4. A pharmacy benefit manager shall not terminate, fail to renew, or limit its contract or agreement with a third party to provide administrative, marketing or other services related to the

offering of a pharmacy benefits plan under the provisions of chapter 689A or 689C of NRS for any reason related to the health status, claims experience, industry, occupation or geographic location of a natural person, family or small employer at the time that the pharmacy benefits plan is issued to or renewed.

5. A denial by a pharmacy benefit manager of an application for coverage under the provisions of chapter 689A or 689C of NRS from a natural person, family or small employer must be in writing and must state the reason for the denial.

6. The Department may adopt regulations that set forth additional standards to provide for the fair marketing and broad availability of pharmacy benefits plans to natural persons, families and small employers in this State.

Sec. 34. *1. The Department:*

(a) Shall suspend or revoke the license of a pharmacy benefit manager if the Department has determined, after notice and a hearing, that the pharmacy benefit manager:

(1) Is in an unsound financial condition;

(2) Uses methods or practices in the conduct of business that are hazardous or injurious to covered persons or members of the general public; or

(3) Has failed to pay any judgment against the pharmacy benefit manager in this State within 60 days after the judgment became final.

(b) May suspend or revoke the license of a pharmacy benefit manager if the Department determines, after notice and a hearing, that the pharmacy benefit manager:

(1) Knowingly violated or failed to comply with any provision of sections 2 to 35, inclusive, of this act or the regulations adopted pursuant thereto;

(2) Has refused to be examined by the Department or has refused to produce accounts, records or files for examination upon the request of the Department;

(3) Has, without just cause, refused to pay claims or perform services pursuant to the contracts of the pharmacy benefit manager or has, without just cause, caused persons to accept less than the amount of money owed to them pursuant to the contracts, or has caused persons to employ an attorney or bring a civil action against the pharmacy benefit manager to receive full payment or settlement of claims;

(4) Is affiliated with, managed by or owned by:

(I) Another pharmacy benefit manager who does not hold a license in this State; or

(II) A third party or an administrator who transacts insurance in this State without a certificate of authority or certificate of registration issued pursuant to title 57 of NRS;

(5) Failed to comply with any of the requirements for a license;

(6) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony or a crime which involves theft, fraud, dishonesty or moral turpitude, whether or not adjudication was withheld;

(7) Has had his or her authority to act as a pharmacy benefit manager in another state limited, suspended or revoked;

(8) Has failed to file an annual report in accordance with section 19 of this act;

(9) Provided incorrect, misleading, incomplete or partially or wholly untrue information in his or her application for a license;

(10) Violated an order of the Department or an officer of another state who has regulatory authority over pharmacy benefit managers;

(11) Has obtained or attempted to obtain a license through misrepresentation or fraud;

(12) Has misappropriated, converted or improperly withheld money or property received in the course of business as a pharmacy benefit manager;

(13) Has intentionally misrepresented the terms of an actual or proposed contract with a third party;

(14) Admitted or is found to have committed an unfair trade practice or fraud;

(15) Used fraudulent, coercive or dishonest practices, or demonstrates incompetence, untrustworthiness or financial irresponsibility in the conduct of business, or otherwise, in this State or elsewhere;

(16) Forged the name of another person or entity on any document relating to the transaction of business as a pharmacy benefit manager;

(17) Failed to pay a tax as required by law;

(18) Failed to comply with the regulations adopted by the Commissioner of Insurance pursuant to NRS 679B.138; or

(19) Engaged in any other conduct defined by regulation of the Department as grounds for disciplinary action.

(c) May suspend or revoke the license of a pharmacy benefit manager if the Department determines, after notice and a hearing, that a responsible person:

(1) Has refused to provide any information relating to the affairs of the pharmacy benefit manager or refused to perform any

other legal obligation relating to an examination upon request by the Department; or

(2) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony committed on or after October 1, 2003, whether or not adjudication was withheld.

(d) May, upon notice to the pharmacy benefit manager, suspend the license of the pharmacy benefit manager pending a hearing if:

(1) The pharmacy benefit manager is impaired or insolvent;

(2) A proceeding for receivership, conservatorship or rehabilitation has been commenced against the pharmacy benefit manager in any state; or

(3) The financial condition or the business practices of the pharmacy benefit manager represent an imminent threat to the public health, safety or welfare of the residents of this State.

(e) May, in addition to or in lieu of the suspension or revocation of the certificate of registration of the pharmacy benefit manager or the refusal to issue a license as a pharmacy benefit manager, impose a fine of $2,000 for each act or violation.

2. As used in this section, "responsible person" means any person who is responsible for or controls or is authorized to control or advise the affairs of a pharmacy benefit manager, including, without limitation:

(a) A member of the board of directors, board of trustees, executive committee or other governing board or committee of the pharmacy benefit manager;

(b) The president, vice president, chief executive officer, chief operating officer or any other principal officer of a pharmacy benefit manager, if the pharmacy benefit manager is a corporation;

(c) A partner or member of the pharmacy benefit manager, if the pharmacy benefit manager is a partnership, association or limited-liability company; and

(d) Any shareholder or member of the pharmacy benefit manager who directly or indirectly holds 10 percent or more of the voting stock, voting securities or voting interest of the pharmacy benefit manager.

Sec. 35. *1. The Department may:*

(a) Impose an administrative fine of not less than $300 and not more than $2,000 against any person who acts as a pharmacy benefit manager without a valid license issued pursuant to this chapter.

(b) Inform the appropriate district attorney of any violation of any provision of this chapter.

2. In addition to any other penalty provided in this chapter, any person violating any provision of this chapter is guilty of a misdemeanor.

Sec. 36. NRS 439B.615 is hereby amended to read as follows:

439B.615 "Pharmacy benefit manager" has the meaning ascribed to it in ~~[~~NRS 683A.174.~~]~~ ***section 6 of this act.***

Sec. 37. NRS 439B.645 is hereby amended to read as follows:

439B.645 ~~[~~1. Except as otherwise provided in subsection 2, on~~]~~ ***On*** or before April 1 of each year, a pharmacy benefit manager shall submit to the Department a report which includes:

~~[~~(a)~~]~~ ***1.*** The total amount of all rebates that the pharmacy benefit manager negotiated with manufacturers during the immediately preceding calendar year for prescription drugs included on the list compiled by the Department pursuant to subsection 1 of NRS 439B.630;

~~[~~(b) The total amount of all rebates described in paragraph (a) that were retained by the pharmacy benefit manager;~~]~~ and

~~[~~(c)~~]~~ ***2.*** The total amount of all rebates described in ~~[~~paragraph (a)~~]~~ ***subsection 1*** that were negotiated for purchases of such drugs for use by:

~~[~~(1)~~]~~ ***(a)*** Recipients of Medicare;

~~[~~(2)~~]~~ ***(b)*** Recipients of Medicaid;

~~[~~(3)~~]~~ ***(c)*** Persons covered by third parties that are governmental entities which are not described in ~~[~~subparagraph (1) or (2);~~]~~ ***paragraph (a) or (b);***

~~[~~(4)~~]~~ ***(d)*** Persons covered by third parties that are not governmental entities; and

~~[~~(5)~~]~~ ***(e)*** Persons covered by a plan ~~[~~described in subsection 2 to the extent required by a contract entered into pursuant to subsection 3.

2. Except as otherwise provided in subsection 3, the requirements of this section do not apply to the coverage of prescription drugs under a plan~~]~~ that is subject to the Employee Retirement Income Security Act of 1974 **.** ~~[~~or any information relating to such coverage.

3. A plan described in subsection 2 may, by contract, require a pharmacy benefit manager that manages the coverage of prescription drugs under the plan to comply with the requirements of this section.~~]~~

Sec. 38. NRS 31A.350 is hereby amended to read as follows:

31A.350 1. If a court orders a parent to obtain health insurance for the parent's child and the parent fails to enroll the child and provide written proof to the enforcing authority, the

enforcing authority shall mail to the parent's employer or labor organization by first-class mail, a notice requiring the employer or organization to enroll the child in the plan of health insurance provided for the employer's employees or the organization's members. The Division of Welfare and Supportive Services shall, by regulation, prescribe the content of the notice and establish procedures for providing the notice to ensure compliance with federal law.

2. Except as otherwise provided in this subsection, upon receipt of a notice to enroll, mailed pursuant to subsection 1, the employer or labor organization shall enroll the child named in the notice in the plan of health insurance provided for the employer's employees or the organization's members. The child must be enrolled without regard to any restrictions upon periods for enrollment. If more than one plan is offered by the employer or labor organization, and each plan may be extended to cover the child, the child must be enrolled in the parent's plan. If the parent's plan cannot be extended to cover the child, the child must be enrolled in a plan that provides coverage for a dependent that is otherwise available to the parent, subject to the eligibility requirements of that plan. An employer, labor organization, health maintenance organization or other insurer is not required to enroll the child in a plan of health insurance if the child is not otherwise eligible to be enrolled in that plan. If the child is not eligible to be enrolled in the parent's plan of health insurance, the employer or labor organization shall notify the enforcing authority.

3. The employer or labor organization shall transfer the notice to enroll to ~~[the]~~ ***any*** administrator ***or pharmacy benefit manager*** that provides coverage pursuant to the plan of health insurance for which the child is eligible within 20 business days after the date of the notice to enroll. The administrator ***or pharmacy benefit manager*** shall fully complete and return the response form to the enforcing authority within 40 business days after the date of the notice.

4. After the child is enrolled in a plan of health insurance, the premiums required to be paid by the parent for the child's coverage must be deducted from the parent's wages. If the parent's wages are not sufficient to pay for those premiums, the employer or labor organization shall notify the enforcing authority. A parent may contest the withholding pursuant to NRS 31A.050.

5. A notice to enroll sent pursuant to subsection 1 has the same effect as an enrollment application signed by the parent. No employer or labor organization may refuse to enroll a child because a parent has not signed an enrollment application.

6. An employer or labor organization shall, without liability to the parent, provide to the enforcing authority, upon request, information about the name of the insurer and the number of the parent's policy of health insurance.

7. The enforcing authority may withhold wages or other income and require withholding of state tax refunds whenever the responsible parent has received payment from the third party and not used the payment to reimburse the other parent or provider to the extent necessary to reimburse the Medicaid agency.

8. The enforcing authority shall promptly notify the employer or labor organization when there is no longer a current order for medical support in effect for which the enforcing authority is responsible.

9. The employer shall notify the enforcing authority when the parent subject to the notice to enroll terminates the parent's employment, and provide the last known address of the parent and the name of any new employer of the parent, if known.

10. If an employer or labor organization wrongfully refuses to enroll a child in a plan of health insurance as required in this section, or knowingly misrepresents that health insurance is not available, the employer or labor organization may be held liable for punitive damages and all unreimbursed medical expenses incurred during the period in which insurance was not in effect.

11. An employer, labor organization or enforcing authority who complies with a notice to enroll that is regular on its face may not be held liable in any civil action for any conduct taken in compliance with the notice.

12. The remedy provided by this section is in addition to, and is not a substitute for, any other remedy available for the enforcement of such an order.

Sec. 39. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 172.075, 172.245, 176.01249, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179D.160, 200.3771,

200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923, 209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 226.300, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.550, 247.560, 250.087, 250.130, 250.140, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 437.145, 437.207, 439.4941, 439.840, 439.914, 439B.420, 439B.754, 439B.760, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 447.345, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.303, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425,

625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.2673, 630.30665, 630.336, 630A.555, 631.368, 632.121, 632.125, 632.3415, 632.405, 633.283, 633.301, 633.4715, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641.221, 641.325, 641A.191, 641A.262, 641A.289, 641B.170, 641B.282, 641B.460, 641C.760, 641C.800, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600 ~~[,]~~ ***and section 26 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without limitation, electronically, the confidential information from the information

included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 40. NRS 281.050 is hereby amended to read as follows:

281.050 1. The residence of a person with reference to his or her eligibility to any office is the person's actual residence within the State, county, district, ward, subdistrict or any other unit prescribed by law, as the case may be, during all the period for which residence is claimed by the person.

2. Except as otherwise provided in subsections 3 and 4, if any person absents himself or herself from the jurisdiction of that person's actual residence with the intention in good faith to return without delay and continue such actual residence, the period of absence must not be considered in determining the question of residence.

3. If a person who has filed a declaration of candidacy for any elective office moves the person's actual residence out of the State, county, district, ward, subdistrict or any other unit prescribed by law, as the case may be, in which the person is required actually, as opposed to constructively, to reside in order for the person to be eligible to the office, a vacancy is created thereby and the appropriate action for filling the vacancy must be taken.

4. Once a person's actual residence is fixed, the person shall be deemed to have moved the person's actual residence for the purposes of this section if:

(a) The person has acted affirmatively and has actually removed himself or herself from the place of permanent habitation where the person actually resided and was legally domiciled;

(b) The person has an intention to abandon the place of permanent habitation where the person actually resided and was legally domiciled; and

(c) The person has an intention to remain in another place of permanent habitation where the person actually resides and is legally domiciled.

5. Except as otherwise provided in this subsection and NRS 293.1265, the district court has jurisdiction to determine the question of residence in any preelection action for declaratory judgment brought against a person who has filed a declaration of candidacy for any elective office. If the question of residence relates to whether an incumbent meets any qualification concerning residence required for the term of office in which the incumbent is presently serving, the district court does not have jurisdiction to determine the question of residence in an action for declaratory judgment brought by a person pursuant to this section but has jurisdiction to determine the question of residence only in an action to declare the office vacant that is authorized by NRS 283.040 and brought by the Attorney General or the appropriate district attorney pursuant to that section.

6. Except as otherwise provided in NRS 293.1265, if in any preelection action for declaratory judgment, the district court finds that a person who has filed a declaration of candidacy for any elective office fails to meet any qualification concerning residence required for the office pursuant to the Constitution or laws of this State, the person is subject to the provisions of NRS 293.2045.

7. For the purposes of this section, in determining whether a place of permanent habitation is the place where a person actually resides and is legally domiciled:

(a) It is the public policy of this State to avoid sham residences and to ensure that the person actually, as opposed to constructively, resides in the area prescribed by law for the office so the person has an actual connection with the constituents who reside in the area and has particular knowledge of their concerns.

(b) The person may have more than one residence but only one legal domicile, and the person's legal domicile requires both the fact of actual living in the place and the intention to remain there as a permanent residence. If the person temporarily leaves the person's legal domicile, or leaves for a particular purpose, and does not take

up a permanent residence in another place, then the person's legal domicile has not changed. Once the person's legal domicile is fixed, the fact of actual living in another place, the intention to remain in the other place and the intention to abandon the former legal domicile must all exist before the person's legal domicile can change.

(c) Evidence of the person's legal domicile includes, without limitation:

(1) The place where the person lives the majority of the time and the length of time the person has lived in that place.

(2) The place where the person lives with the person's spouse or domestic partner, if any.

(3) The place where the person lives with the person's children, dependents or relatives, if any.

(4) The place where the person lives with any other individual whose relationship with the person is substantially similar to a relationship with a spouse, domestic partner, child, dependent or relative.

(5) The place where the person's dogs, cats or other pets, if any, live.

(6) The place listed as the person's residential address on the voter registration card, as defined in NRS 293.1205, issued to the person.

(7) The place listed as the person's residential address on any driver's license or identification card issued to the person by the Department of Motor Vehicles, any passport or military identification card issued to the person by the United States or any other form of identification issued to the person by a governmental agency.

(8) The place listed as the person's residential address on any registration for a motor vehicle issued to the person by the Department of Motor Vehicles or any registration for another type of vehicle or mode of transportation, including, without limitation, any aircraft, vessels or watercraft, issued to the person by a governmental agency.

(9) The place listed as the person's residential address on any applications for issuance or renewal of any license, certificate, registration, permit or similar type of authorization issued to the person by a governmental agency which has the authority to regulate an occupation or profession.

(10) The place listed as the person's residential address on any document which the person is authorized or required by law to file or record with a governmental agency, including, without limitation, any deed, declaration of homestead or other record of real or personal property, any applications for services, privileges or

benefits or any tax documents, forms or returns, but excluding the person's declaration of candidacy.

(11) The place listed as the person's residential address on any type of check, payment, benefit or reimbursement issued to the person by a governmental agency or by any type of company that provides insurance, workers' compensation, health care or medical benefits or any self-insured employer ***,*** ~~[or]~~ third-party administrator ~~[.]~~ ***or pharmacy benefit manager.***

(12) The place listed as the person's residential address on the person's paycheck, paystub or employment records.

(13) The place listed as the person's residential address on the person's bank statements, insurance statements, mortgage statements, loan statements, financial accounts, credit card accounts, utility accounts or other billing statements or accounts.

(14) The place where the person receives mail or deliveries from the United States Postal Service or commercial carriers.

(d) The evidence listed in paragraph (c) is intended to be illustrative and is not intended to be exhaustive or exclusive. The presence or absence of any particular type of evidence listed in paragraph (c) is not, by itself, determinative of the person's legal domicile, but such a determination must be based upon all the facts and circumstances of the person's particular case.

8. As used in this section:

(a) "Actual residence" means the place of permanent habitation where a person actually resides and is legally domiciled. If the person maintains more than one place of permanent habitation, the place the person declares to be the person's principal permanent habitation when filing a declaration of candidacy for any elective office must be the place where the person actually resides and is legally domiciled in order for the person to be eligible to the office.

(b) "Declaration of candidacy" has the meaning ascribed to it in NRS 293.0455.

Sec. 41. NRS 287.0434 is hereby amended to read as follows:

287.0434 ***1.*** The Board may:

~~[1.]~~ ***(a)*** Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

~~[2.]~~ ***(b)*** Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators ***, pharmacy benefit managers*** and qualified actuaries. ~~[Each such contract with a licensed administrator:~~

~~(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative~~

~~actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.~~

~~(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.~~

~~3.~~] *(c)* Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

~~(a)~~] *(1)* Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

~~(b)~~] *(2)* The rates set forth in the contract are based on:

~~(1)~~] *(I)* For active and retired state officers and employees and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool; and

~~(2)~~] *(II)* For active and retired officers and employees of public agencies enumerated in NRS 287.010 that contract with the Program to obtain group insurance by participation in the Program and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool.

~~4.~~] *(d)* Enter into contracts for the services of other experts and specialists as required by the Program.

~~5.~~] *(e)* Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the Board or a participating public agency in administering a plan of insurance offered by that insurer, organization or corporation.

~~6.~~] *(f)* Charge and collect the amount due from local governments pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment of a local government pursuant to that provision is delinquent by more than 90 days, the Board shall notify the Executive Director of the Department of Taxation pursuant to NRS 354.671.

2. Any contract described in paragraph (b) of subsection 1 with a licensed administrator:

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

become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

(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.

3. Any contract described in paragraph (b) of subsection 1 with a pharmacy benefit manager:

(a) Must be submitted to the Department of Health and Human Services not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the pharmacy benefit manager and status of any legal or administrative actions in this State against the pharmacy benefit manager that may impair his or her ability to provide the services in the contract.

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

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

Sec. 42. NRS 353.097 is hereby amended to read as follows:

353.097 1. As used in this section, "stale claim" means any claim which is presented by a state agency to the State Board of Examiners:

(a) If the claim was eligible to be paid from money that was appropriated, after the date on which it is provided by law that money appropriated to that state agency for the previous fiscal year reverts to the fund from which appropriated; or

(b) If the claim was eligible to be paid from money that was authorized, after the last day of the fiscal year in which that state agency was authorized to expend the money.

2. There is hereby created a Stale Claims Account in the State General Fund. Money for the Account must be provided by direct legislative appropriation.

3. Upon the approval of a stale claim pursuant to subsection 4, the claim must be paid from the Stale Claims Account. Payments of such stale claims for a state agency must not exceed:

(a) If the claim was eligible to be paid from money that was appropriated, the amount of money reverted to the fund from which appropriated by the state agency for the fiscal year in which the obligations represented by the stale claims were incurred; or

(b) If the claim was eligible to be paid from money that was authorized, the balance on the last day of the fiscal year of money

that the state agency was authorized to expend during the fiscal year.

4. Except as otherwise provided in this section, a stale claim must be approved for payment from the Stale Claims Account by the State Board of Examiners. The State Board of Examiners may authorize its Clerk or a person designated by the Clerk, under such circumstances as it deems appropriate, to approve stale claims on behalf of the Board. A state agency that is aggrieved by a determination of the Clerk or the person designated by the Clerk to deny all or any part of a stale claim may appeal that determination to the State Board of Examiners.

5. A stale claim may be approved and paid at any time, despite the age of the claim, if payable from available federal grants or from a permanent fund in the State Treasury other than the State General Fund.

6. A state agency may pay from the appropriate budget account in the current fiscal year a stale claim of the state agency which is:

(a) Less than $100;

(b) For medical expenses pursuant to a claim from a third-party administrator; ~~[or]~~

(c) ***For expenses on prescription drugs pursuant to a claim from a pharmacy benefit manager; or***

(d) For payroll expenses.

Sec. 43. NRS 422.4023 is hereby amended to read as follows:

422.4023 "Pharmacy benefit manager" has the meaning ascribed to it in ~~[NRS 683A.174.]~~ ***section 6 of this act.***

Sec. 44. NRS 422.4053 is hereby amended to read as follows:

422.4053 1. Except as otherwise provided in subsection 2, the Department shall directly manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program.

2. The Department may enter into a contract with:

(a) A pharmacy benefit manager for the provision of any services described in subsection 1.

(b) A health maintenance organization pursuant to NRS 422.273 for the provision of any of the services described in subsection 1 for recipients of Medicaid or recipients of insurance through the Children's Health Insurance Program who receive coverage through a Medicaid managed care program.

3. A contract entered into pursuant to subsection 2 must:

(a) Include the provisions required by NRS 422.4056; and

(b) Require the pharmacy benefit manager or health maintenance organization, as applicable, to disclose to the

Department any information relating to the services covered by the contract, including, without limitation, information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees and charges imposed by the pharmacy benefit manager or health maintenance organization pursuant to the contract.

4. In addition to meeting the requirements of subsection 3, a contract entered into pursuant to ~~[~~:

~~(a) Paragraph (a) of subsection 2 may require the pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department.~~

~~(b) Paragraph~~] ***paragraph*** (b) of subsection 2 must require the health maintenance organization to provide to the Department the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, less an administrative fee in an amount prescribed by the contract. The Department shall adopt policies prescribing the maximum amount of such an administrative fee.

Sec. 45. Chapter 616A of NRS is hereby amended by adding thereto a new section to read as follows:

"Pharmacy benefit manager" means a person who is hired by an insurer to manage coverage of prescription drugs.

Sec. 46. NRS 616A.025 is hereby amended to read as follows:

616A.025 As used in chapters 616A to 616D, inclusive, of NRS, unless the context otherwise requires, the words and terms defined in NRS 616A.030 to 616A.360, inclusive, ***and section 45 of this act*** have the meanings ascribed to them in those sections.

Sec. 47. NRS 616A.335 is hereby amended to read as follows:

616A.335 "Third-party administrator" means a person who is hired by an insurer to provide administrative services for the insurer and manage claims. The term ~~[does]~~ ***:***

1. Includes a pharmacy benefit manager who is hired by an insurer to manage coverage of prescription drugs.

2. Does not include an insurance company.

Sec. 48. NRS 616A.400 is hereby amended to read as follows:

616A.400 The Administrator shall:

1. Prescribe by regulation the time within which adjudications and awards must be made.

2. Regulate forms of notices, claims and other blank forms deemed proper and advisable.

3. Prescribe by regulation the methods by which an insurer may approve or reject claims, and may determine the amount and nature of benefits payable in connection therewith.

4. Prescribe by regulation the method for reimbursing an injured employee for expenses necessarily incurred for travel more than 20 miles one way from the employee's residence or place of employment to his or her destination as a result of an industrial injury.

5. Determine whether an insurer or third-party administrator has provided adequate facilities in this State to administer claims and for the retention of a file on each claim.

6. Evaluate the services of private carriers provided to employers in:

(a) Controlling losses; and

(b) Providing information on the prevention of industrial accidents or occupational diseases.

7. Conduct such investigations and examinations of insurers or third-party administrators as the Administrator deems reasonable to determine whether any person has violated the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or to obtain information useful to enforce or administer these chapters.

8. Prescribe by regulation the qualifications for final approval by the Division of an applicant for a certificate of registration as an administrator pursuant to subsection 3 of NRS 683A.08524 ~~[.]~~ ***or a license as a pharmacy benefit manager pursuant to subsection 3 of section 16 of this act.*** The regulations must set forth qualifications which provide for the final approval of those applicants whose approval is in the best interests of the people of this State.

9. Except with respect to any matter committed by specific statute to the regulatory authority of another person or agency, adopt such other regulations as the Administrator deems necessary to carry out the provisions of chapters 616A to 617, inclusive, of NRS.

Sec. 49. NRS 616B.318 is hereby amended to read as follows:

616B.318 1. The Commissioner shall impose an administrative fine, not to exceed $1,000 for each violation, and:

(a) Shall withdraw the certification of a self-insured employer if:

(1) The deposit required pursuant to NRS 616B.300 is not sufficient and the employer fails to increase the deposit after the employer has been ordered to do so by the Commissioner;

(2) The self-insured employer fails to provide evidence of excess insurance pursuant to NRS 616B.300 within 45 days after the employer has been so ordered; or

(3) Except as otherwise provided in subsection 4, the employer becomes insolvent, institutes any voluntary proceeding

under the Bankruptcy Act or is named in any involuntary proceeding thereunder.

(b) May withdraw the certification of a self-insured employer if:

(1) The employer intentionally fails to comply with regulations of the Commissioner regarding reports or other requirements necessary to carry out the purposes of chapters 616A to 616D, inclusive, and chapter 617 of NRS;

(2) The employer violates the provisions of subsection 2 ***or 3*** of NRS 616B.500 or any regulation adopted by the Commissioner or the Administrator concerning the administration of the employer's plan of self-insurance; or

(3) The employer makes a general or special assignment for the benefit of creditors or fails to pay compensation after an order for payment of any claim becomes final.

2. Any employer whose certification as a self-insured employer is withdrawn must, on the effective date of the withdrawal, qualify as an employer pursuant to NRS 616B.650.

3. The Commissioner may, upon the written request of an employer whose certification as a self-insured employer is withdrawn pursuant to subparagraph (3) of paragraph (a) of subsection 1, reinstate the employer's certificate for a reasonable period to allow the employer sufficient time to provide industrial insurance for his or her employees.

4. The Commissioner may authorize an employer to retain his or her certification as a self-insured employer during the pendency of a proceeding specified in subparagraph (3) of paragraph (a) of subsection 1 if the employer establishes to the satisfaction of the Commissioner that the employer is able to pay all claims for compensation during the pendency of the proceeding.

Sec. 50. NRS 616B.350 is hereby amended to read as follows:

616B.350 1. A group of five or more employers may not act as an association of self-insured public employers unless the group:

(a) Is composed of employers engaged in the same or similar classifications of employment; and

(b) Has been issued a certificate to act as such an association by the Commissioner.

2. A group of five or more employers may not act as an association of self-insured private employers unless each member of the group:

(a) Is a member or associate member of a bona fide trade association, as determined by the Commissioner, which:

(1) Is incorporated in this State; and

(2) Has been in existence for at least 5 years; and

(b) Has been issued a certificate to act as such an association by the Commissioner.

3. An association of public or private employers that wishes to be issued a certificate must file with the Commissioner an application for certification.

4. The application must include:

(a) The name of the association.

(b) The address of:

(1) The principal office of the association.

(2) The location where the books and records of the association will be maintained.

(c) The date the association was organized.

(d) The name and address of each member of the association.

(e) The names of the initial members of the board of trustees and the name of the initial association's administrator.

(f) Such other information as the Commissioner may require.

5. The application must be accompanied by:

(a) A nonrefundable filing fee of $1,000 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

(b) Proof of compliance with NRS 616B.353.

(c) Proof that ~~[the]~~ ***:***

(1) The association or its third-party administrator ***, other than a pharmacy benefit manager,*** is licensed or otherwise authorized to conduct business in this State pursuant to title 57 of NRS ~~[.]~~ ***; and***

(2) Any pharmacy benefit manager with which the association or its third-party administrator has entered into a contract for the management of prescription drug coverage is licensed pursuant to sections 2 to 35, inclusive, of this act.

(d) A copy of the agreements entered into with the association's administrator and a third-party administrator.

(e) A copy of the bylaws of the association.

(f) A copy of an agreement jointly and severally binding the association and each member of the association to secure the payment of all compensation due pursuant to chapters 616A to 617, inclusive, of NRS.

(g) A pro forma financial statement prepared by an independent certified public accountant in accordance with generally accepted accounting principles that shows the financial ability of the association to pay all compensation due pursuant to chapters 616A to 617, inclusive, of NRS.

(h) A reviewed financial statement prepared by an independent certified public accountant for each proposed member of the association or evidence of the ability of the association or its proposed members to provide a solvency bond pursuant to subsection 3 of NRS 616B.353.

(i) Proof that each member of the association will make the initial payment to the association required pursuant to NRS 616B.416 on a date specified by the Commissioner. The payment shall be deemed to be a part of the assessment required to be paid by each member for the first year of self-insurance if certification is issued to the association.

6. Except as otherwise provided in NRS 239.0115, any financial information relating to a member of an association received by the Commissioner pursuant to the provisions of this section is confidential and must not be disclosed.

7. For the purposes of this section, "associate member of a bona fide trade association" means a supplier whose business, as determined by the Commissioner:

(a) Is limited to a specific industry; and

(b) Primarily involves providing a product or service that is directly used or consumed by substantially all of the members of the trade association or bears a direct relationship to the business of the members of the association.

Sec. 51. NRS 616B.500 is hereby amended to read as follows:

616B.500 1. An insurer may enter into a contract to have his or her plan of insurance administered by a third-party administrator.

2. An insurer shall not enter into a contract with any person for the administration of any part of the plan of insurance ***, except for coverage of prescription drugs,*** unless that person maintains an office in this State and has a certificate issued by the Commissioner pursuant to NRS 683A.08524.

3. An insurer shall not enter into a contract with any person for the administration of coverage of prescription drugs unless that person maintains an office in this State and is licensed as a pharmacy benefit manager by the Department of Health and Human Services pursuant to section 16 of this act.

Sec. 52. NRS 616B.503 is hereby amended to read as follows:

616B.503 1. A person shall not act as ~~[a]~~ ***:***

(a) A third-party administrator ***, other than a pharmacy benefit manager,*** for an insurer without a certificate issued by the Commissioner pursuant to NRS 683A.08524.

(b) A pharmacy benefit manager for an insurer without a license issued by the Department of Health and Human Services pursuant to section 16 of this act.

2. A person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS shall:

(a) Administer from one or more offices located in this State all of the claims arising under each plan of insurance that the person administers and maintain in those offices all of the records concerning those claims;

(b) Administer each plan of insurance directly, without subcontracting with another third-party administrator; and

(c) Upon the termination of the person's contract with an insurer, transfer forthwith to a certified third-party administrator chosen by the insurer all of the records in the person's possession concerning claims arising under the plan of insurance.

3. The Commissioner may, under exceptional circumstances, waive the requirements of subsection 2.

Sec. 53. NRS 616B.506 is hereby amended to read as follows:

616B.506 ***1.*** The Commissioner shall impose an administrative fine, not to exceed $1,000 for each violation, ***against any third-party administrator*** and may withdraw the certification of any third-party administrator ***, other than a pharmacy benefit manager,*** who:

~~[1.]~~ ***(a)*** Fails to comply with regulations of the Commissioner regarding reports or other requirements necessary to carry out the purposes of chapters 616A to 616D, inclusive, or chapter 617 of NRS; or

~~[2.]~~ ***(b)*** Violates any provision of NRS 616B.503 or any regulation adopted by the Commissioner or the Administrator concerning the administration of the plan of insurance.

2. The Department of Health and Human Services may revoke the license of a pharmacy benefit manager who commits any violation described in paragraph (a) or (b) of subsection 1.

Sec. 54. NRS 616D.120 is hereby amended to read as follows:

616D.120 1. Except as otherwise provided in this section, if the Administrator determines that an insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company has:

(a) Induced a claimant to fail to report an accidental injury or occupational disease;

(b) Without justification, persuaded a claimant to:

(1) Settle for an amount which is less than reasonable;

(2) Settle for an amount which is less than reasonable while a hearing or an appeal is pending; or

(3) Accept less than the compensation found to be due the claimant by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the Division when carrying out its duties pursuant to chapters 616A to 617, inclusive, of NRS;

(c) Refused to pay or unreasonably delayed payment to a claimant of compensation or other relief found to be due the claimant by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the Division when carrying out its duties pursuant to chapters 616A to

616D, inclusive, or chapter 617 of NRS, if the refusal or delay occurs:

(1) Later than 10 days after the date of the settlement agreement or stipulation;

(2) Later than 30 days after the date of the decision of a court, hearing officer, appeals officer or the Division, unless a stay has been granted; or

(3) Later than 10 days after a stay of the decision of a court, hearing officer, appeals officer or the Division has been lifted;

(d) Refused to process a claim for compensation pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(e) Made it necessary for a claimant to initiate proceedings pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for compensation or other relief found to be due the claimant by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the Division when carrying out its duties pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(f) Failed to comply with the Division's regulations covering the payment of an assessment relating to the funding of costs of administration of chapters 616A to 617, inclusive, of NRS;

(g) Failed to provide or unreasonably delayed payment to an injured employee or reimbursement to an insurer pursuant to NRS 616C.165;

(h) Engaged in a pattern of untimely payments to injured employees; or

(i) Intentionally failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 616A, 616B, 616C or 617 of NRS,

➥ the Administrator shall impose an administrative fine of $1,500 for each initial violation, or a fine of $15,000 for a second or subsequent violation.

2. Except as otherwise provided in chapters 616A to 616D, inclusive, or chapter 617 of NRS, if the Administrator determines that an insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company has failed to comply with any provision of this chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto, the Administrator may take any of the following actions:

(a) Issue a notice of correction for:

(1) A minor violation, as defined by regulations adopted by the Division; or

(2) A violation involving the payment of compensation in an amount which is greater than that required by any provision of this

chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto.

➥ The notice of correction must set forth with particularity the violation committed and the manner in which the violation may be corrected. The provisions of this section do not authorize the Administrator to modify or negate in any manner a determination or any portion of a determination made by a hearing officer, appeals officer or court of competent jurisdiction or a provision contained in a written settlement agreement or written stipulation.

(b) Impose an administrative fine for:

(1) A second or subsequent violation for which a notice of correction has been issued pursuant to paragraph (a); or

(2) Any other violation of this chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto, for which a notice of correction may not be issued pursuant to paragraph (a).

➥ The fine imposed must not be greater than $375 for an initial violation, or more than $3,000 for any second or subsequent violation.

(c) Order a plan of corrective action to be submitted to the Administrator within 30 days after the date of the order.

3. If the Administrator determines that a violation of any of the provisions of paragraphs (a) to (e), inclusive, (h) or (i) of subsection 1 has occurred, the Administrator shall order the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company to pay to the claimant a benefit penalty:

(a) Except as otherwise provided in paragraph (b), in an amount that is not less than $5,000 and not greater than $50,000; or

(b) Of $3,000 if the violation involves a late payment of compensation or other relief to a claimant in an amount which is less than $500 or which is not more than 14 days late.

4. To determine the amount of the benefit penalty, the Administrator shall consider the degree of physical harm suffered by the injured employee or the dependents of the injured employee as a result of the violation of paragraph (a), (b), (c), (d), (e), (h) or (i) of subsection 1, the amount of compensation found to be due the claimant and the number of fines and benefit penalties, other than a benefit penalty described in paragraph (b) of subsection 3, previously imposed against the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company pursuant to this section. The Administrator shall also consider the degree of economic harm suffered by the injured employee or the dependents of the injured employee as a result of the violation of paragraph (a), (b), (c), (d),

(e), (h) or (i) of subsection 1. Except as otherwise provided in this section, the benefit penalty is for the benefit of the claimant and must be paid directly to the claimant within 10 days after the date of the Administrator's determination. If the claimant is the injured employee and the claimant dies before the benefit penalty is paid to him or her, the benefit penalty must be paid to the estate of the claimant. Proof of the payment of the benefit penalty must be submitted to the Administrator within 10 days after the date of the Administrator's determination unless an appeal is filed pursuant to NRS 616D.140. Any compensation to which the claimant may otherwise be entitled pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS must not be reduced by the amount of any benefit penalty received pursuant to this subsection. To determine the amount of the benefit penalty in cases of multiple violations occurring within a certain period of time, the Administrator shall adopt regulations which take into consideration:

(a) The number of violations within a certain number of years for which a benefit penalty was imposed; and

(b) The number of claims handled by the insurer, organization for managed care, health care provider, third-party administrator, employer or employee leasing company in relation to the number of benefit penalties previously imposed within the period of time prescribed pursuant to paragraph (a).

5. In addition to any fine or benefit penalty imposed pursuant to this section, the Administrator may assess against an insurer who violates any regulation concerning the reporting of claims expenditures or premiums received that are used to calculate an assessment an administrative penalty of up to twice the amount of any underpaid assessment.

6. If:

(a) The Administrator determines that a person has violated any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310 or 616D.350 to 616D.440, inclusive; and

(b) The Fraud Control Unit for Industrial Insurance of the Office of the Attorney General established pursuant to NRS 228.420 notifies the Administrator that the Unit will not prosecute the person for that violation,

➥ the Administrator shall impose an administrative fine of not more than $15,000.

7. Two or more fines of $1,000 or more imposed in 1 year for acts enumerated in subsection 1 must be considered by ~~[the]~~ ***:***

(a) By the Commissioner as evidence for the withdrawal of:

~~[(a)]~~ ***(1)*** A certificate to act as a self-insured employer.

~~[(b)]~~ ***(2)*** A certificate to act as an association of self-insured public or private employers.

~~[(c)]~~ ***(3)*** A certificate of registration as a third-party administrator.

(b) By the Department of Health and Human Services as evidence for the withdrawal of a license as a pharmacy benefit manager.

8. The Commissioner may, without complying with the provisions of NRS 616B.327 or 616B.431, withdraw the certification of a self-insured employer, association of self-insured public or private employers or third-party administrator if, after a hearing, it is shown that the self-insured employer, association of self-insured public or private employers or third-party administrator violated any provision of subsection 1.

9. If the Administrator determines that a vocational rehabilitation counselor has violated the provisions of NRS 616C.543, the Administrator may impose an administrative fine on the vocational rehabilitation counselor of not more than $250 for a first violation, $500 for a second violation and $1,000 for a third or subsequent violation.

10. The Administrator may make a claim against the bond required pursuant to NRS 683A.0857 ***or section 20 of this act*** for the payment of any administrative fine or benefit penalty imposed for a violation of the provisions of this section.

Sec. 55. NRS 616D.130 is hereby amended to read as follows:

616D.130 1. Upon receipt of a complaint for a violation of subsection 1 of NRS 616D.120, or if the Administrator has reason to believe that such a violation has occurred, the Administrator shall cause to be conducted an investigation of the alleged violation. Except as otherwise provided in subsection 2, the Administrator shall, within 30 days after initiating the investigation:

(a) Render a determination. The determination must include the Administrator's findings of fact and, if the Administrator determines that a violation has occurred, one or more of the following:

(1) The amount of any fine required to be paid pursuant to NRS 616D.120.

(2) The amount of any benefit penalty required to be paid to a claimant pursuant to NRS 616D.120.

(3) A plan of corrective action to be taken by the insurer, organization for managed care, health care provider, third-party administrator or employer, including the manner and time within which the violation must be corrected.

(4) A requirement that notice of the violation be given to the appropriate agency that regulates the activities of the violator.

(b) Notify the Commissioner if the Administrator determines that a violation was committed by a self-insured employer,

association of self-insured public or private employers or third-party administrator.

(c) Additionally notify the Department of Health and Human Services if the Administrator determines that a violation was committed by a pharmacy benefit manager.

2. Upon receipt of a complaint for any violation of paragraph (a), (b), (c) or (d) of subsection 1 of NRS 616D.120, or if the Administrator has reason to believe that such a violation has occurred, the Administrator shall complete the investigation required by subsection 1 within 60 days and, within 30 days after the completion of the investigation, render a determination and notify the Commissioner if the Administrator determines that a violation was committed by a self-insured employer, association of self-insured public or private employers or third-party administrator. ***The Administrator shall additionally notify the Department of Health and Human Services if the Administrator determines that a violation was committed by a pharmacy benefit manager.***

3. If, based upon the Administrator's findings of fact, the Administrator determines that a violation has not occurred, the Administrator shall issue a determination to that effect.

Sec. 56. Chapter 679A of NRS is hereby amended by adding thereto a new section to read as follows:

"Pharmacy benefit manager" has the meaning ascribed to it in section 6 of this act.

Sec. 57. NRS 679A.020 is hereby amended to read as follows:

679A.020 As used in this Code, unless the context otherwise requires, the words and terms defined in NRS 679A.030 to 679A.130, inclusive, ***and section 56 of this act*** have the meanings ascribed to them in those sections.

Sec. 58. NRS 679A.118 is hereby amended to read as follows:

679A.118 "Provider of insurance" includes an insurer, producer of insurance, managing general agent, third-party administrator, organization composed of or using preferred providers of health care, health maintenance organization, commercial bank, trust company, savings and loan association, savings bank, credit union, thrift company, financial holding company, affiliate or subsidiary of an insurer or financial holding company, broker-dealer in securities, mortgage lender, and any other person engaged in the business of insurance. ***The term does not include a pharmacy benefit manager licensed pursuant to sections 2 to 35, inclusive, of this act.***

Sec. 59. NRS 679B.133 is hereby amended to read as follows:

679B.133 1. If a health care plan that provides coverage for prescription drugs or devices issues a single identification card or other device to an insured that contains information solely needed to

process a claim for a prescription drug or device, the card or other device must conform to the requirements of the National Council for Prescription Drug Programs set forth in the NCPDP Pharmacy ID Card Implementation Guide that are consistent with applicable regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as they may be amended from time to time, or must contain at least the following elements:

(a) The name or logo of the administrator ***or pharmacy benefit manager*** issuing the card or device.

(b) The insured's identification number, which must be displayed on the front side of the card or device.

(c) The name and address of the administrator ***or pharmacy benefit manager*** to which prescription claims that are not processed electronically or correspondence should be sent.

(d) The telephone number that providers may call for assistance concerning pharmacy benefits.

(e) Complete information concerning routing of electronic transactions, including, without limitation, the international identification number and, if required by the administrator ***or pharmacy benefit manager*** to process the claim, the processing control number and group number.

➥ The information on the card or device must be arranged in a manner that corresponds both in content and form to the content and form required by the plan to process the claim.

2. The Commissioner shall adopt such regulations as are necessary to carry out the provisions of this section.

3. As used in this section:

(a) "Administrator" has the meaning ascribed to it in NRS 683A.025 **.** ~~[, and includes a pharmacy benefits manager.]~~

(b) "Health care plan" has the meaning ascribed to it in NRS 679B.520.

Sec. 60. NRS 679B.138 is hereby amended to read as follows:

679B.138 1. The Commissioner shall adopt regulations which require the use of uniform claim forms and billing codes and the ability to make compatible electronic data transfers for all insurers **,** ~~[and]~~ administrators ***and pharmacy benefit managers*** authorized to conduct business in this state relating to a health care plan or health insurance or providing or arranging for the provision of health care services, including, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation, a health maintenance organization, a plan for dental care and a prepaid limited health service organization. The regulations must include,

without limitation, a uniform billing format to be used for the submission of claims to such insurers and administrators.

2. As used in this section:

(a) "Administrator" has the meaning ascribed to it in NRS 683A.025.

(b) "Health care plan" means a policy, contract, certificate or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Sec. 61. NRS 680A.082 is hereby amended to read as follows:

680A.082 The Commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the Commissioner that the following requirements have been satisfied by the arrangement:

1. The employers participating in the arrangement are members of a bona fide association.

2. The employers participating in the arrangement exercise control over the arrangement, as follows:

(a) Subject to paragraph (b), control exists if the board of directors of the bona fide association or the employers participating in the arrangement have the right to elect at least 75 percent of the individuals designated in the arrangement's organizational documents as having control over operations of the arrangement and individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement; and

(b) The use of a third-party administrator ***or a pharmacy benefit manager*** to process claims and to assist in the administration of the arrangement is not evidence of the lack of control over the operation of the arrangement.

3. In this State, the arrangement provides only health care services.

4. In this State, the arrangement provides or arranges benefits for health care services in compliance with the provisions of this title that mandate particular benefits or offerings and with provisions that require access to particular types or categories of health care providers and facilities.

5. The arrangement provides health care services to not less than 20 employers and not less than 75 employees.

6. The arrangement may not solicit participation in the arrangement from the general public. However, the arrangement may employ licensed insurance producers who receive a commission, unlicensed individuals who do not receive a commission, and may contract with a licensed insurance producer

who may be paid a commission or other remuneration, for the purpose of enrolling and renewing the enrollments of employers in the arrangement.

7. The arrangement has been in existence and operated actively for a continuous period of not less than 10 years as of December 31, 2018, except for an arrangement that has been in existence and operated actively since December 31, 2015, and is sponsored by an association that has been in existence more than 25 years.

8. The arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company.

9. The arrangement has aggregate stop loss coverage, with an attachment point of 120 percent of expected claims.

Sec. 62. NRS 683A.025 is hereby amended to read as follows:

683A.025 1. Except as limited by this section, "administrator" means a person who:

(a) Directly or indirectly underwrites or collects charges or premiums from or adjusts or settles claims of residents of this State or any other state from within this State in connection with workers' compensation insurance, life or health insurance coverage or annuities, including coverage or annuities provided by an employer for his or her employees;

(b) Administers an internal service fund pursuant to NRS 287.010;

(c) Administers a trust established pursuant to NRS 287.015, under a contract with the trust;

(d) Administers a program of self-insurance for an employer;

(e) Administers a program which is funded by an employer and which provides pensions, annuities, health benefits, death benefits or other similar benefits for his or her employees; or

(f) Is an insurance company that is licensed to do business in this State or is acting as an insurer with respect to a policy lawfully issued and delivered in a state where the insurer is authorized to do business, if the insurance company performs any act described in paragraphs (a) to (e), inclusive, for or on behalf of another insurer unless the insurers are affiliated and each insurer is licensed to do business in this State.

2. "Administrator" does not include:

(a) An employee authorized to act on behalf of an administrator who holds a certificate of registration from the Commissioner.

(b) An employer acting on behalf of his or her employees or the employees of a subsidiary or affiliated concern.

(c) A labor union acting on behalf of its members.

(d) Except as otherwise provided in paragraph (f) of subsection 1, an insurance company licensed to do business in this State or

acting as an insurer with respect to a policy lawfully issued and delivered in a state in which the insurer was authorized to do business.

(e) A producer of life or health insurance licensed in this State, when his or her activities are limited to the sale of insurance.

(f) A creditor acting on behalf of his or her debtors with respect to insurance covering a debt between the creditor and debtor.

(g) A trust and its trustees, agents and employees acting for it, if the trust was established under the provisions of 29 U.S.C. § 186.

(h) Except as otherwise provided in paragraph (c) of subsection 1, a trust and its trustees, agents and employees acting for it, if the trust was established pursuant to NRS 287.015.

(i) A trust which is exempt from taxation under section 501(a) of the Internal Revenue Code, 26 U.S.C. § 501(a), its trustees and employees, and a custodian, his or her agents and employees acting under a custodial account which meets the requirements of section 401(f) of the Internal Revenue Code, 26 U.S.C. § 401(f).

(j) A bank, credit union or other financial institution which is subject to supervision by federal or state banking authorities.

(k) A company which issues credit cards, and which advances for and collects premiums or charges from credit card holders who have authorized it to do so, if the company does not adjust or settle claims.

(l) An attorney at law who adjusts or settles claims in the normal course of his or her practice or employment, but who does not collect charges or premiums in connection with life or health insurance coverage or with annuities.

(m) A pharmacy benefit manager licensed pursuant to sections 2 to 35, inclusive, of this act.

3. As used in this section, "affiliated" means any insurer or other person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, another insurer or other person.

Sec. 63. NRS 684A.020 is hereby amended to read as follows:

684A.020 1. Except as otherwise provided in subsection 2, "adjuster" means any person who, for compensation, including, without limitation, a fee or commission, investigates and settles, and reports to his or her principal relative to, claims:

(a) Arising under insurance contracts for property, casualty or surety coverage, including, without limitation, workers' compensation coverage, on behalf solely of the insurer or the insured; or

(b) Against a self-insurer who is providing similar coverage.

2. For the purposes of this chapter:

(a) An attorney at law who adjusts insurance losses from time to time incidental to the practice of his or her profession;

(b) An adjuster of ocean marine losses;

(c) A salaried employee of an insurer, unless the employee:

(1) Investigates, negotiates or settles workers' compensation claims; and

(2) Obtains a license pursuant to this chapter;

(d) A salaried employee of a managing general agent maintaining an underwriting office in this state;

(e) An employee of an independent adjuster or an employee of an affiliate of an independent adjuster who is one of not more than 25 such employees under the supervision of an independent adjuster or licensed agent and who:

(1) Collects information relating to a claim for coverage arising under an insurance contract from or furnishes such information to an insured or a claimant; and

(2) Conducts data entry, including, without limitation, entering data into an automated claims adjudication system;

(f) A licensed agent who supervises not more than 25 employees described in paragraph (e);

(g) A person who is employed only to collect factual information concerning a claim for coverage arising under an insurance contract;

(h) A person who is employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster;

(i) A person who is employed to investigate suspected fraudulent insurance claims but who does not adjust losses or determine the payment of claims;

(j) A person who performs only executive, administrative, managerial or clerical duties, or any combination thereof, but does not investigate, negotiate or settle claims with a policyholder or claimant or the legal representative of a policyholder or claimant;

(k) A licensed health care provider or any employee thereof who provides managed care services if those services do not include the determination of compensability;

(l) A managed care organization or any employee thereof or an organization that provides managed care services or any employee thereof if the services provided do not include the determination of compensability;

(m) A person who settles only reinsurance or subrogation claims;

(n) A broker, agent or representative of a risk retention group;

(o) An attorney-in-fact of a reciprocal insurer;

(p) A manager of a branch office of an alien insurer that is located in the United States; or

(q) A person authorized to adjust claims under the authority of a third-party administrator who holds a certificate of registration issued by the Commissioner pursuant to NRS 683A.08524 ~~[.]~~ ***or a pharmacy benefit manager licensed by the Department of Health and Human Services pursuant to section 16 of this act,*** unless the person investigates, negotiates or settles workers' compensation claims,

➥ is not considered an adjuster.

Sec. 64. NRS 684A.030 is hereby amended to read as follows:

684A.030 1. "Independent adjuster" means an adjuster who is representing the interests of an insurer or a self-insurer and who:

(a) Contracts for compensation with the insurer or self-insurer as an independent contractor or an employee of an independent contractor;

(b) Is treated for tax purposes by the insurer or self-insurer in a manner consistent with an independent contractor rather than an employee; and

(c) Investigates, negotiates or settles property, casualty or surety claims, including, without limitation, workers' compensation claims, for the insurer or self-insurer.

2. "Public adjuster" means an adjuster employed by and representing solely the financial interests of the insured named in the policy. The term does not include an adjuster who investigates, negotiates or settles workers' compensation claims.

3. "Company adjuster" means a salaried employee of an insurer who:

(a) Investigates, negotiates or settles property, casualty or surety claims, including, without limitation, workers' compensation claims; and

(b) Obtains a license pursuant to this chapter.

4. "Staff adjuster" means a person who investigates, negotiates or settles workers' compensation claims under the authority of ~~[a]~~ ***:***

(a) A third-party administrator who holds ~~[a]~~ certificate of registration issued by the Commissioner pursuant to NRS 683A.08524 ~~[.]~~ ***; or***

(b) A pharmacy benefit manager licensed by the Department of Health and Human Services pursuant to section 16 of this act.

Sec. 65. NRS 687B.697 is hereby amended to read as follows:

687B.697 1. A health carrier and third parties are obligated to comply with NRS 687B.694 and 687B.696 concerning the services referenced on a remittance advice or explanation of payment. A provider of health care may refuse the discount taken on the remittance advice or explanation of payment if the discount is taken

without a contractual basis or in violation of NRS 687B.693 or 687B.695. An error in the remittance advice or explanation of payment may be corrected not more than 30 days after given notice of the error by the provider of health care.

2. A health carrier may not lease, rent or otherwise grant to a third party, access to a provider network contract unless the third party accessing the provider network contract is:

(a) A payer or third party, administrator ***, pharmacy benefit manager*** or other entity that administers or processes claims on behalf of the payer;

(b) A preferred provider of health care organization or preferred provider of health care network, including a physician organization or a physician-hospital organization; or

(c) An entity engaged in the electronic claims transport between the health carrier and the payer that does not provide access to the services and discounts of a provider of health care to any other third party.

Sec. 66. NRS 689B.280 is hereby amended to read as follows:

689B.280 1. Except as otherwise provided in subsection 2, an insurer or any agent or employee of an insurer who delivers or issues for delivery a policy of group health or blanket health insurance in this State shall not disclose to the policyholder or any agent or employee of the policyholder:

(a) The fact that an insured is taking a prescribed drug or medicine; or

(b) The identity of that drug or medicine.

2. The provisions of subsection 1 do not prohibit disclosure to an administrator ***or pharmacy benefit manager*** who acts as an intermediary for claims for insurance coverage.

Sec. 67. NRS 689C.540 is hereby amended to read as follows:

689C.540 A voluntary purchasing group shall:

1. Establish administrative and accounting procedures for the operation of the group and the provision of services to members, prepare an annual budget and annual operational fiscal reports;

2. Provide for internal and independent audits; and

3. Maintain all records, reports and other information of the group and may contract with qualified third-party administrators, ***pharmacy benefit managers,*** licensed insurance agents or brokers as needed.

Sec. 68. NRS 683A.171, 683A.172, 683A.173, 683A.174, 683A.175, 683A.176, 683A.177, 683A.178 and 683A.179 are hereby repealed.

Sec. 69. 1. Notwithstanding any provision of this act to the contrary, any person who holds a certificate of registration as an administrator issued by the Commissioner of Insurance pursuant to

NRS 683A.08524 and is acting as a pharmacy benefit manager on or before January 1, 2022, must meet the requirements for licensure as a pharmacy benefit manager and obtain a license as required by section 12 of this act, not later than July 1, 2022.

2. The certificate of registration as an administrator held by a person described in subsection 1 shall also be deemed to be a license as a pharmacy benefit manager issued by the Department of Health and Human Services until July 1, 2022, or the date on which the holder obtains a license as a pharmacy benefit manager from the Department, whichever is earlier. Before that date, the holder of the certificate is subject to:

(a) The provisions of sections 2 to 35, inclusive, of this act, with regard to his or her activity as a pharmacy benefit manager; and

(b) The provisions of Title 57 of NRS, with regard to any other activity as an administrator.

3. As used in this section, "pharmacy benefit manager" has the meaning ascribed to it in section 6 of this act.

Sec. 70. 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.

Sec. 71. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 70, inclusive, of this act become effective:

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

(b) On January 1, 2022, for all other purposes.

3. Sections 14 and 15 of this act expire by limitation on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.

LEADLINES OF REPEALED SECTIONS

683A.171 Definitions.
683A.172 "Covered person" defined.
683A.173 "Pharmacy" defined.
683A.174 "Pharmacy benefit manager" defined.
683A.175 "Pharmacy benefits plan" defined.
683A.176 "Third party" defined.
683A.177 Applicability.
683A.178 Obligation of pharmacy benefit manager to third party or pharmacy; notice of conflicts of interest.
683A.179 Prohibited acts; applicability.

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