SENATE BILL NO. 2–SENATOR AMODEI

PREFILED JANUARY 11, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Requires provider of insurance coverage for prescription drugs to disclose certain information regarding use of formulary and to continue coverage for prescribed drug under certain circumstances. (BDR 57-597)

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

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

AN ACT relating to insurance; requiring a provider of coverage for prescription drugs to disclose certain information regarding the use of a formulary; prohibiting such a provider from limiting or excluding coverage for a prescribed drug under certain circumstances; and providing other matters properly relating thereto.

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

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

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 3. *1. Except as otherwise provided in this section, a policy of health insurance which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:*

(a) Had previously been approved for coverage by the insurer for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the policy that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 4. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 5 and 6 of this act.

Sec. 5. *1. An insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the*

insurer pursuant to subsection 2. The notice required by this subsection must:

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 6. *1. Except as otherwise provided in this section, a policy of group health insurance which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:*

(a) Had previously been approved for coverage by the insurer for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the policy that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 7. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 8, 9 and 10 of this act.

Sec. 8. ***1. A carrier that offers or issues a health benefit plan which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the carrier pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 9. ***1. Except as otherwise provided in this section, a health benefit plan which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:***

(a) Had previously been approved for coverage by the carrier for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The carrier from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the plan that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 10. ***1. A carrier that offers or issues a contract which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the carrier pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 11. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, ***and section 10 of this act*** are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 8 and 9 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 689C.360 to 689C.600, inclusive, and ~~[this section.]~~ ***section 10 of this act.***

Sec. 12. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 13 and 14 of this act.

Sec. 13. *1. A society that offers or issues a benefit contract which provides coverage for prescription drugs shall include with any certificate for such a contract provided to a benefit member, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the society pursuant to subsection 2. The notice required by this subsection must:*

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 14. *1. Except as otherwise provided in this section, a benefit contract which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:*

(a) Had previously been approved for coverage by the society for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The society from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the

insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the benefit contract that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 15. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 16 and 17 of this act.

Sec. 16. ***1. An insurer that offers or issues a contract for hospital or medical services which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the insurer pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 17. ***1. Except as otherwise provided in this section, a contract for hospital or medical services which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:***

(a) Had previously been approved for coverage by the insurer for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the contract that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a contract for hospital or medical services subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 18. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 19 and 20 of this act.

Sec. 19. ***1. A health maintenance organization or insurer that offers or issues evidence of coverage which provides coverage for prescription drugs shall include with any evidence of that coverage provided to an enrollee, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization or insurer pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

(2) A copy of the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more

than one formulary is maintained, the organization or insurer shall notify the requester that a choice of formulary lists is available.

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

Sec. 20. *1. Except as otherwise provided in this section, evidence of coverage which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:*

(a) Had previously been approved for coverage by the health maintenance organization or insurer for a medical condition of an enrollee and the enrollee's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the enrollee.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The health maintenance organization or insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the enrollee or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the evidence of coverage that is medically appropriate for the enrollee; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of an evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 21. NRS 695C.050 is hereby amended to read as follows:

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

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

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

4. The provisions of NRS 695C.110, 695C.170 to 695C.200, inclusive, *and sections 19 and 20 of this act, NRS* 695C.250 and 695C.265 do not

apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the state plan for Medicaid or insurance pursuant to the children's health insurance program pursuant to a contract with the division of health care financing and policy of the department of human resources. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 and 695C.1695 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the state plan for Medicaid.

Sec. 22. Chapter 695F of NRS is hereby amended by adding thereto the provisions set forth as sections 23 and 24 of this act.

Sec. 23. ***1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for prescription drugs shall include with any evidence of that coverage provided to a subscriber, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

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

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

Sec. 24. ***1. Except as otherwise provided in this section, evidence of coverage which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:***

(a) Had previously been approved for coverage by the prepaid limited health service organization for a medical condition of an enrollee and

the enrollee's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the enrollee.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The organization from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the enrollee or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the evidence of coverage that is medically appropriate for the enrollee; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of an evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

Sec. 25. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 26 and 27 of this act.

Sec. 26. ***1. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the organization pursuant to subsection 2. The notice required by this subsection must:***

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

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

(c) If a formulary is used, include:

(1) An explanation of:

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

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

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

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

(a) Provide to any person, upon request:

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

(2) A copy of the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more

than one formulary is maintained, the organization shall notify the requester that a choice of formulary lists is available.

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

Sec. 27. *1. Except as otherwise provided in this section, a health care plan which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:*

(a) Had previously been approved for coverage by the managed care organization for a medical condition of an insured and the insured's provider of health care continues to prescribe the drug for the medical condition; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration; or

(b) Prohibit:

(1) The organization from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs;

(2) A provider of health care from prescribing another drug covered by the plan that is medically appropriate for the insured; or

(3) The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2599, inclusive.

3. Any provision of a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

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