SENATE BILL NO. 192–SENATORS MATHEWS; CARE, LEE AND RHOADS

MARCH 10, 2009

JOINT SPONSORS: ASSEMBLYMEN ANDERSON, GRADY, LESLIE AND PARNELL

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to required insurance coverage for certain prescription drugs. (BDR 57-720)

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 health insurance; revising certain provisions regarding required insurance coverage for previously approved prescription drugs; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 1-8 of this bill revise certain provisions governing required insurance coverage for previously approved prescription drugs. (NRS 689A.04045, 689B.0368, 689C.168, 695A.184, 695B.1905, 695C.1734, 695F.156, 695G.166) The revisions alter the provisions related to continuing coverage for previously approved prescription drugs by changing the test in existing law for requiring continued coverage from: (1) mandating an investigation and determination that no other currently approved drug is appropriate for the insured; to: (2) whether the provider of health care continues to prescribe the drug. This bill also prohibits an insurer from increasing the cost-sharing obligations of the insured for a narrow therapeutic index drug.

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

Section 1. NRS 689A.04045 is hereby amended to read as follows:

689A.04045 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;]~~ ***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;

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[or]~~ ***, except that the insurer may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescriptions drugs;***

(2) The insurer from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the policy that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the policy.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 2. NRS 689B.0368 is hereby amended to read as follows:

689B.0368 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;]~~ ***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;

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[or]~~ ***, except that the insurer may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The insurer from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the policy that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the policy.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 3. NRS 689C.168 is hereby amended to read as follows:

689C.168 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;]~~ ***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;

(b) Prohibit:

(1) The carrier from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[or]~~ ***, except that the carrier may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The carrier from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the plan that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the plan.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 4. NRS 695A.184 is hereby amended to read as follows:

695A.184 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;]~~ ***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;

(b) Prohibit:

(1) The society from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[or]~~ ***, except that the society may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The society from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the benefit contract that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the benefit contract.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 5. NRS 695B.1905 is hereby amended to read as follows:

695B.1905 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;]~~ ***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;

(b) Prohibit:

(1) The insurer from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[or]~~ ***, except that the insurer may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing***

the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;

(2) The insurer from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the contract that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the contract.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 6. NRS 695C.1734 is hereby amended to read as follows:

695C.1734 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the enrollee;]~~ ***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;

(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]~~ ***, except that the health maintenance organization or insurer may not, in any manner, increase the enrollee's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The health maintenance organization or insurer from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[(2)]~~ ***(3)*** A provider of health care from prescribing another drug covered by the evidence of coverage that is medically appropriate for the enrollee; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the evidence of coverage.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 7. NRS 695F.156 is hereby amended to read as follows:

695F.156 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 ~~[determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the enrollee;]~~ ***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;

(b) Prohibit:

(1) The organization from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the enrollee ~~[or]~~ ***, except that the organization may not, in any manner, increase the enrollee's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The organization from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[~~(2)~~]~~ ***(3)*** A provider of health care from prescribing another drug covered by the evidence of coverage that is medically appropriate for the enrollee; or

~~[~~(3)~~]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the evidence of coverage.

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.

4. As used in this section, "narrow therapeutic index drug" has the meaning ascribed to it in NRS 695G.166.

Sec. 8. NRS 695G.166 is hereby amended to read as follows:

695G.166 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 ~~[~~determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured;~~]~~ ***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;

(b) Prohibit:

(1) The organization from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured ~~[~~or~~]~~ ***, except that the organization may not, in any manner, increase the insured's cost-sharing obligations for a narrow therapeutic index drug, including, without limitation, by placing the narrow therapeutic index drug on a different formulary tier as regards the provision of benefits for prescription drugs;***

(2) The organization from establishing, by contract, limitations on the maximum coverage for prescription drugs;

~~[~~(2)~~]~~ ***(3)*** A provider of health care from prescribing another drug covered by the plan that is medically appropriate for the insured; or

~~[(3)]~~ ***(4)*** The substitution of another drug pursuant to NRS 639.23286 or 639.2583 to 639.2597, inclusive; or

(c) Require any coverage for a drug after the term of the plan.

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.

4. As used in this section, "narrow therapeutic index drug" means a drug that has:

(a) A narrow difference in its effective concentration and toxic concentration in blood; and

(b) Requires pharmacodynamic and therapeutic drug concentration monitoring.

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