SENATE BILL NO. 222–SENATOR ATKINSON

MARCH 5, 2015

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Revises provisions relating to health insurance covering prescription drugs. (BDR 57-670)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§§ 22, 23)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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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; limiting the copayment or coinsurance required to be paid by certain persons for prescription drugs; requiring certain policies of health insurance and health care plans that provide prescription drug coverage to provide an exception process for prescription drugs which are not included in the formulary of the policy or plan; prohibiting certain policies of health insurance and health care plans from placing all prescription drugs in a given class within the highest cost tier of the plan; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires certain public and private policies of insurance and health care plans to provide coverage for certain procedures, including colorectal cancer screenings, cytological screening tests and mammograms, in certain circumstances. (NRS 287.027, 287.04335, 689A.04042, 689A.0405, 689B.0367, 689B.0374, 695B.1907, 695B.1912, 695C.1731, 695C.1735, 695G.168) Existing law also requires employers to provide certain benefits to employees, including coverage for the procedures required to be covered by insurers, if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 1, 5, 8, 11, 14, 19, 22 and 24** of this bill require certain public and private policies of insurance and health care plans to: (1) limit a person's copayment or coinsurance for prescription drugs to not more than $50 per prescription per month and not more than 20 percent of the maximum out-of-pocket limit included in the federal Patient Protection and Affordable Care Act for all prescription drugs within a given year; (2) provide that the limits on coinsurance must apply regardless of whether the amount of the

annual deductible has been satisfied; (3) not place all prescription drugs within a given class within the highest cost tier provided by the policy or plan; and (4) provide an exceptions process which allows an insured person to request an exception to the drug formulary if his or her doctor determines that a prescription drug which is not included in the formulary will be more effective or the person will suffer an adverse effect from the prescription drug which is included in the formulary.

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

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

1. A policy of health insurance that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of health insurance; and

(e) Provide that if the policy of health insurance uses a specialty drug formulary, it must also include an exceptions process that allows an insured to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the insured as the non-formulary drug or that the formulary drug will have an adverse effect for the insured.

2. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy of health insurance which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be

construed to preclude an insurer from requiring a prescription drug covered under a policy of health insurance to be obtained through a pharmacy or other drug distribution source designated by the insurer.

Sec. 2. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[;]~~ ***subject to the provisions of section 1 of this act;***

(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 639.2597, 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.

Sec. 3. NRS 689A.0447 is hereby amended to read as follows:

689A.0447 1. An insurer that offers or issues a policy of health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 1 of this act.*** The limitation on the amount of the deductible that may be required pursuant to

this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 4. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 1 of this act.***

Sec. 5. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of group health insurance that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of group health insurance; and

(e) Provide that if the policy of group health insurance uses a specialty drug formulary, it must also include an exceptions process that allows an insured to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the insured as the non-formulary drug or that the formulary drug will have an adverse effect for the insured.

2. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy of group health insurance which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be construed to preclude an insurer from requiring a prescription drug covered under a policy of group health insurance to be obtained through a pharmacy or other drug distribution source designated by the insurer.

Sec. 6. NRS 689B.0362 is hereby amended to read as follows:

689B.0362 1. An insurer that offers or issues a policy of group health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 5 of this act.*** The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 7. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[,]~~ ***subject to the provisions of section 5 of this act;***

(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 639.2597, 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.

Sec. 8. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the health benefit plan; and

(e) Provide that if the health benefit plan uses a specialty drug formulary, it must also include an exceptions process that allows an insured to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the insured as the non-formulary drug or that the formulary drug will have an adverse effect for the insured.

2. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the health benefit plan which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be construed to preclude a carrier from requiring a prescription drug covered under a health benefit plan to be obtained through a pharmacy or other drug distribution source designated by the carrier.

Sec. 9. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[;]~~ ***subject to the provisions of section 8 of this act;***

(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 639.2597, 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.

Sec. 10. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and section 8 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 11. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of health insurance; and

(e) Provide that if the policy of health insurance uses a specialty drug formulary, it must also include an exceptions process that allows an insured to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the insured as the non-formulary drug or that the formulary drug will have an adverse effect for the insured.

2. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the policy of health insurance which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be construed to preclude a hospital or medical service corporation from requiring a prescription drug covered under a policy of health insurance to be obtained through a pharmacy or other drug distribution source designated by the corporation.

Sec. 12. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[;]~~ ***subject to the provisions of section 11 of this act;***

(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 639.2597, 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.

Sec. 13. NRS 695B.1909 is hereby amended to read as follows:

695B.1909 1. An insurer that offers or issues a contract for hospital or medical service which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 11 of this act.*** The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A contract subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any

provision of the contract or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 14. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an enrollee for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an enrollee for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the health care plan; and

(e) Provide that if the health care plan uses a specialty drug formulary, it must also include an exceptions process that allows an enrollee to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the enrollee as the non-formulary drug or that the formulary drug will have an adverse effect for the enrollee.

2. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the health care plan which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be construed to preclude a health maintenance organization from requiring a drug covered under a health care plan to be obtained through a pharmacy or other drug distribution source designated by the health maintenance organization.

Sec. 15. NRS 695C.050 is hereby amended to read as follows:

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

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

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170 to 695C.173, inclusive, 695C.1733 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 ***and section 14 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 16. NRS 695C.17335 is hereby amended to read as follows:

695C.17335 1. A health maintenance organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 14 of this act.*** The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. Evidence of coverage subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring a health maintenance organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 17. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[,]~~ ***subject to the provisions of section 14 of this act;***

(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 639.2597, 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.

Sec. 18. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 14 of this act,*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 19. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan that provides coverage for prescription drugs must:

(a) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs to an amount not greater than $50 per month for a 30-day supply of each prescription drug;

(b) Limit any copayment or coinsurance required to be paid by an insured for prescription drugs on an annual basis to an amount not greater than 20 percent of the out-of-pocket maximum specified in section 1302(c)(1) of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(c)(1), as amended;

(c) Provide that the limits on coinsurance provided in this section must apply regardless of whether the amount of the annual deductible has been satisfied;

(d) Not place all prescription drugs in a given class within the highest cost tier designated in the health care plan; and

(e) Provide that if the health care plan uses a specialty drug formulary, it must also include an exceptions process that allows an insured to request an exception to the formulary. The exception process must allow a prescription drug which is not included in the formulary to be covered on the same basis, and under the same terms, as a prescription drug which is included in the formulary if the prescribing physician determines that the formulary drug for the condition being treated will not be as effective for the insured as the non-formulary drug or that the formulary drug will have an adverse effect for the insured.

2. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2015, has the legal effect of including the coverage required by this section, and any provision of the health care plan which is in conflict with this section is void.

3. Nothing in this section or any other provision of this chapter or any regulations adopted pursuant thereto shall be construed to preclude a managed care organization from requiring a prescription drug covered under a health care plan to be obtained through a pharmacy or other drug distribution source designated by the managed care organization.

Sec. 20. 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; 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 from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~[;]~~ ***subject to the provisions of section 19 of this act;***

(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 639.2597, 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.

Sec. 21. NRS 695G.167 is hereby amended to read as follows:

695G.167 1. A managed care organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 19 of this act.*** The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 22. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and section 5 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

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

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

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

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 23. NRS 287.0278 is hereby amended to read as follows:

287.0278 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of

self-insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than ~~[$100 per prescription.]~~ ***the maximum amount allowed by section 5 of this act.*** The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in NRS 687B.470, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A plan of self-insurance subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the plan or the renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of self-insurance to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 24. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.167, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, ***and section 19 of this act*** and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 25. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 26. This act becomes effective on July 1, 2015.

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