

CHAPTER.....

AN ACT relating to health insurance; prohibiting an insurer from taking certain actions concerning prescription drugs covered by certain policies of health insurance; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Under existing law, policies of health insurance may provide coverage for prescription drugs. Prescription drugs which are covered by a policy of health insurance are organized into a formulary, which is an official list of the prescription drugs, and that formulary may be subcategorized based upon the cost to the insured person to purchase the prescription drug under the policy of health insurance. These subcategories are referred to as tiers. If a particular prescription drug is moved by the insurer from a lower cost tier to a higher cost tier, the insured person purchasing the prescription drug will need to pay more to purchase the prescription drug after the prescription drug is moved to the higher cost tier.

**Section 1** of this bill prohibits certain insurers from moving a prescription drug from a lower cost tier to a higher cost tier under certain policies of health insurance issued to an individual or a small employer, except on specified dates or when an applicable generic drug is added to the formulary under specified circumstances. **Section 1** does not prevent such an insurer from: (1) moving a prescription drug from a higher cost tier to a lower cost tier; (2) removing a prescription drug from a formulary; or (3) adding a prescription drug to a formulary. Further, **section 1** does not limit the conditions under which a pharmacist is otherwise authorized or required to substitute: (1) a generic drug for a drug prescribed by brand name; or (2) an interchangeable biological product for a biological product prescribed by brand name.

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

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

**Section 1.** Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. If a policy of health insurance issued to an individual pursuant to chapter 689A, 695B or 695C of NRS includes coverage for a prescription drug pursuant to a formulary with more than one cost tier, the insurer may move the prescription drug from a lower cost tier to a higher cost tier only:*

*(a) On January 1; and*

*(b) On any date on which the insurer adds to the formulary a generic prescription drug that:*

*(1) Has been approved by the Food and Drug Administration for use as an alternative to the original prescription drug; and*



*(2) Is being added to the formulary at:*

*(I) The same cost tier from which the original prescription drug is being moved; or*

*(II) A cost tier which has a smaller deductible, copayment or coinsurance than the cost tier from which the original prescription drug is being moved.*

*2. If a policy of health insurance issued to a small employer pursuant to chapter 689C, 695B or 695C of NRS includes coverage for a prescription drug pursuant to a formulary with more than one cost tier, the insurer may move the prescription drug from a lower cost tier to a higher cost tier only:*

*(a) On January 1;*

*(b) On July 1; and*

*(c) On any date on which the insurer adds to the formulary a generic prescription drug that:*

*(i) Has been approved by the Food and Drug Administration for use as an alternative to the original prescription drug; and*

*(2) Is being added to the formulary at:*

*(I) The same cost tier from which the original prescription drug is being moved; or*

*(II) A cost tier which has a smaller deductible, copayment or coinsurance than the cost tier from which the original prescription drug is being moved.*

*3. The provisions of this section do not prevent an insurer, at any time, from:*

*(a) Moving a prescription drug from a higher cost tier of a formulary to a lower cost tier of the formulary;*

*(b) Removing a prescription drug from a formulary; or*

*(c) Adding a prescription drug to a formulary.*

*4. This section does not apply to a grandfathered plan.*

*5. The provisions of this section must not be construed to limit the conditions under which a pharmacist is otherwise authorized or required by law to substitute:*

*(a) A generic drug for a drug prescribed by brand name; or*

*(b) An interchangeable biological product for a biological product prescribed by brand name.*

*6. As used in this section:*

*(a) "Biological product" has the meaning ascribed to it in section 2 of Assembly Bill No. 245 of this session.*

*(b) "Individual carrier" has the meaning ascribed to it in NRS 689A.550.*

*(c) "Insurer" includes, without limitation:*



*(1) An individual carrier; and  
(2) A governmental entity which offers, administers or otherwise provides a policy of health insurance.*

*(d) “Interchangeable biological product” has the meaning ascribed to it in section 3 of Assembly Bill No. 245 of this session.*

*(e) “Small employer” has the meaning ascribed to it in NRS 689C.095.*

**Secs. 2-4.** (Deleted by amendment.)

**Sec. 5.** This act becomes effective on January 1, 2019.

