ASSEMBLY BILL NO. 185–ASSEMBLYMEN SPIEGEL, BILBRAY-AXELROD; BENITEZ-THOMPSON, COHEN, DURAN, FUMO, JAUREGUI, MCCURDY, MONROE-MORENO, MUNK, SWANK, THOMPSON AND WATTS

FEBRUARY 18, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to insurance coverage of prescription drugs. (BDR 57-277)

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

CONTAINS UNFUNDED MANDATE (§§ 9, 10)
(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; requiring an insurer to allow an insured to credit the amount paid for a prescription drug under certain circumstances toward any applicable deductible; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires an insurer, other than a health benefit plan for public employees, that provides coverage for prescription drugs to provide an insured with certain information concerning prescription drug coverage. (NRS 689A.405, 689B.0283, 689C.281, 689C.455, 695A.255, 695B.176, 695C.1703, 695F.153, 695G.163) This bill requires an insurer, including a health benefit plan for public employees, to allow an insured to credit the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

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

Section 1. NRS 689A.405 is hereby amended to read as follows:

689A.405 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

(c) During each period for open enrollment, publish on an Internet website that is operated by the insurer and accessible to the public or include in any enrollment materials distributed by the insurer a notice of all prescription drugs that:

(1) Are included on the most recent list of drugs that are essential for treating diabetes in this State compiled by the Department of Health and Human Services pursuant to subsection 1 of NRS 439B.630; and

(2) Have been removed or will be removed from the formulary during the current plan year or the next plan year.

(d) Update the notice required by paragraph (c) throughout the period for open enrollment.

3. An insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 2. NRS 689B.0283 is hereby amended to read as follows:

689B.0283 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. An insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 3. NRS 689C.281 is hereby amended to read as follows:

689C.281 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. A carrier that offers or issues a health benefit plan which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 4. NRS 689C.455 is hereby amended to read as follows:

689C.455 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. A carrier that offers or issues a contract which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 5. NRS 695A.255 is hereby amended to read as follows:

695A.255 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. A society that offers or issues a benefit contract which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 6. NRS 695B.176 is hereby amended to read as follows:

695B.176 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. An insurer that offers or issues a contract for hospital or medical services which provides coverage for prescription drugs

shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 7. NRS 695C.1703 is hereby amended to read as follows:

695C.1703 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 enrollee or participating provider of health care upon request:

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

(2) Access to 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.

3. A health maintenance organization or insurer that offers or issues evidence of coverage which provides coverage for prescription drugs shall allow an enrollee to credit toward any applicable deductible the amount paid by the enrollee for a covered prescription drug for which the enrollee paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug. Notwithstanding the provisions of NRS 695C.050, the provisions of this subsection apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid and insurance pursuant to the Children's Health Insurance Program.

Sec. 8. NRS 695F.153 is hereby amended to read as follows:

695F.153 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 enrollee or participating provider of health care, upon request:

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

(2) Access to 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.

3. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for prescription drugs shall allow an enrollee to credit toward any applicable deductible the amount paid by the enrollee for a covered prescription drug for which the enrollee paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 9. NRS 695G.163 is hereby amended to read as follows:

695G.163 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 insured or participating provider of health care, upon request:

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

(2) Access to 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.

3. A managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 10. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

If the governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada establishes coverage for prescription drugs pursuant to NRS 287.010 or 287.015 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, such coverage must allow an insured to credit toward any applicable deductible the amount paid by the insured for a covered prescription drug for which the insured paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

Sec. 11. NRS 287.043 is hereby amended to read as follows:

287.043 1. The Board shall:

(a) Establish and carry out a program to be known as the Public Employees' Benefits Program which:

(1) Must include a program relating to group life, accident or health insurance, or any combination of these; and

(2) May include:

(I) A plan that offers flexibility in benefits, and for which the rates must be based only on the experience of the participants in the plan and not in combination with the experience of participants in any other plan offered under the Program; or

(II) A program to reduce taxable compensation or other forms of compensation other than deferred compensation,

➥ for the benefit of all state officers and employees and other persons who participate in the Program.

(b) Ensure that the Program is funded on an actuarially sound basis and operated in accordance with sound insurance and business practices.

2. In establishing and carrying out the Program, the Board shall:

(a) For the purpose of establishing actuarial data to determine rates and coverage for active and retired state officers and

employees and their dependents, commingle the claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage into a single risk pool.

(b) Except as otherwise provided in this paragraph, negotiate and contract pursuant to paragraph (a) of subsection 1 of NRS 287.025 with the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that wishes to obtain exclusive group insurance for all of its active and retired officers and employees and their dependents, except as otherwise provided in sub-subparagraph (III) of subparagraph (2) of paragraph (h), by participation in the Program. The Board shall establish separate rates and coverage for active and retired officers and employees of those local governmental agencies and their dependents based on actuarial reports that commingle the claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage into a single risk pool.

(c) Except as otherwise provided in paragraph (d), provide public notice in writing of any proposed changes in rates or coverage to each participating public agency that may be affected by the changes. Notice must be provided at least 30 days before the effective date of the changes.

(d) If a proposed change is a change in the premium or contribution charged for, or coverage of, health insurance, provide written notice of the proposed change to all participants in the Program. The notice must be provided at least 30 days before the date on which a participant in the Program is required to select or change the participant's policy of health insurance.

(e) Purchase policies of life, accident or health insurance, or any combination of these, or, if applicable, a program to reduce the amount of taxable compensation pursuant to 26 U.S.C. § 125, from any company qualified to do business in this State or provide similar coverage through a plan of self-insurance established pursuant to NRS 287.0433 for the benefit of all eligible participants in the Program.

(f) Except as otherwise provided in this title, develop and establish other employee benefits as necessary.

(g) Investigate and approve or disapprove any contract proposed pursuant to NRS 287.0479.

(h) Adopt such regulations and perform such other duties as are necessary to carry out the provisions of NRS 287.010 to 287.245, inclusive, ***and section 10 of this act,*** including, without limitation, the establishment of:

(1) Fees for applications for participation in the Program and for the late payment of premiums or contributions;

(2) Conditions for entry and reentry into and exit from the Program by local governmental agencies pursuant to paragraph (a) of subsection 1 of NRS 287.025, which:

(I) Must include a minimum period of 4 years of participation for entry into the Program;

(II) Must include a requirement that participation of any retired officers and employees of the local governmental agency whose last continuous period of enrollment with the Program began after November 30, 2008, terminates upon termination of the local governmental agency's contract with the Program; and

(III) May allow for the exclusion of active and retired officers and employees of the local governmental agency who are eligible for health coverage from a health and welfare plan or trust that arose out of collective bargaining under chapter 288 of NRS or a trust established pursuant to 29 U.S.C. § 186;

(3) Procedures by which a group of participants in the Program may leave the Program pursuant to NRS 287.0479 and conditions and procedures for reentry into the Program by those participants;

(4) Specific procedures for the determination of contested claims;

(5) Procedures for review and notification of the termination of coverage of persons pursuant to paragraph (b) of subsection 4 of NRS 287.023; and

(6) Procedures for the payments that are required to be made pursuant to paragraph (b) of subsection 4 of NRS 287.023.

3. The Board may use any services provided to state agencies and shall use the services of the Purchasing Division of the Department of Administration to establish and carry out the Program.

4. The Board may engage the services of an attorney who specializes in health plans and health care law as necessary to assist in carrying out the Program.

5. The Board may make recommendations to the Legislature concerning legislation that it deems necessary and appropriate regarding the Program.

6. A participating public agency is not liable for any obligation of the Program other than indemnification of the Board and its employees against liability relating to the administration of the Program, subject to the limitations specified in NRS 41.0349.

7. ***If the Board purchases or provides coverage for prescription drugs pursuant to paragraph (e) of subsection 2, such coverage must allow a participant in the Program to credit toward***

any applicable deductible the amount paid by the participant for a covered prescription drug for which the participant paid the cash price instead of using the coverage and paying the deductible, copayment or coinsurance required for the prescription drug.

8. As used in this section, "employee benefits" includes any form of compensation provided to a public employee except federal benefits, wages earned, legal holidays, deferred compensation and benefits available pursuant to chapter 286 of NRS.

Sec. 12. The amendatory provisions of this act do not apply to a contract entered into before January 1, 2020, to provide coverage for prescription drugs, but apply to any extension or renewal thereof.

Sec. 13. 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. 14. This act becomes effective:

1. Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and
2. On January 1, 2020, for all other purposes.

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