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FIRST REPRINT **S.B. 167**

SENATE BILL NO. 167–SENATORS DONDERO LOOP, SPEARMAN; CANNIZZARO, DALY, D. HARRIS, KRASNER, NEAL, NGUYEN, OHRENSCHALL, PAZINA AND SCHEIBLE

FEBRUARY 16, 2023

JOINT SPONSOR: ASSEMBLYWOMAN THOMAS

Referred to Committee on Commerce and Labor

SUMMARY—Prohibits the imposition of step therapy under certain circumstances. (BDR 57-81)

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

CONTAINS UNFUNDED MANDATE (§ 13)
(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 insurance; prohibiting the imposition of a step therapy protocol for a drug prescribed to treat a psychiatric condition under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prohibits a policy of health insurance which provides coverage for prescription drugs, including a policy of health insurance provided by a local government or private employer for its employees, from limiting or excluding coverage for a drug if the drug: (1) 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 (2) is appropriately prescribed and considered safe and effective for treating the medical condition of the insured. (NRS 689A.04045, 689B.0368, 689C.168, 695A.184, 695B.1905, 695C.1734, 695F.156, 695G.166) Existing law also requires the Department of Health and Human Services to establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs. (NRS 422.403) **Sections 1, 3-9 and 11-15** of this bill prohibit private insurers, voluntary purchasing groups, insurance plans for state, local and private employees and Medicaid from imposing a step therapy protocol for a drug that is approved by the United States Food and Drug

Administration or that medical or scientific evidence establishes may be used to treat a psychiatric condition if: (1) a practitioner who meets certain requirements prescribed the drug; and (2) that practitioner reasonably expects each drug that is required to be dispensed according to the step therapy protocol to be ineffective. **Section 2** of this bill makes a conforming change to indicate the proper placement of **section 1** in the Nevada Revised Statutes. **Section 10** of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of authority of a health maintenance organization that fails to comply with the requirements of **section 8** of this bill. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of **sections 1, 3-8, 11 and 12** of this bill. (NRS 680A.200)

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 which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the insurer is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of 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, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her policy of health insurance provides coverage for the recommended drug.

Sec. 2. 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. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of group health insurance which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1),

(2) or (3) who participates in the network plan of the insurer is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of 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, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her policy of group health insurance provides coverage for the recommended drug.

Sec. 4. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph

(1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the health carrier is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. 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 July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the health carrier. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her health benefit plan provides coverage for the recommended drug.

Sec. 5. 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 4 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. 6. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A benefit contract which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the society is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her benefit contract provides coverage for the recommended drug.

Sec. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance offered or issued by a hospital or medical services corporation which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of

the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the hospital or medical services corporation is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. Any provision of 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, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her policy of health insurance offered or issued by a hospital or medical services corporation provides coverage for the recommended drug.

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan which provides coverage for prescription drugs must not require an enrollee to submit to a step therapy protocol before covering a drug approved by the Food and

Drug Administration that is prescribed to treat a psychiatric condition of the enrollee, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the enrollee or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an enrollee in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the health maintenance organization is located 60 miles or more from the residence of the enrollee; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the enrollee, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. 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 July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an enrollee to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the enrollee before his or her health care plan provides coverage for the recommended drug.

Sec. 9. 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, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 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 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 ***and section 8 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. 10. 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 8 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 or creditors or to the general public;

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

1. Evidence of coverage which provides coverage for prescription drugs must not require an enrollee to use a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the enrollee, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the enrollee or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an enrollee in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the prepaid limited health service organization is located 60 miles or more from the residence of the enrollee; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the enrollee, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. 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 July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means evidence of coverage offered by a prepaid limited health service organization under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the prepaid limited health service organization. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an enrollee to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the enrollee before his or her evidence of coverage provides coverage for the recommended drug.

Sec. 12. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of the insured, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in the network plan of the managed care organization is located 60 miles or more from the residence of the insured; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

2. 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 July 1, 2023, which is in conflict with this section is void.

3. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Step therapy protocol" means a procedure that requires an insured to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the insured before his or her health care plan provides coverage for the recommended drug.

Sec. 13. 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 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, ***and section 3 of this act,*** 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(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. 14. 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 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, ***and section 12 of this act,*** 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 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. 15. NRS 422.403 is hereby amended to read as follows:

422.403 1. The Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. The Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures for use by the Medicaid program for prescription drugs; and

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.

3. ***The step therapy protocol established pursuant to this section must not apply to a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of a recipient of Medicaid, if:***

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of

the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in Medicaid is located 60 miles or more from the residence of the recipient; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the recipient, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

4. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed pursuant to NRS 422.4025.

~~[4.]~~ ***5.*** The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.

6. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Step therapy protocol" means a procedure that requires a recipient of Medicaid to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the recipient before Medicaid provides coverage for the recommended drug.

Sec. 16. 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. 17. This act becomes effective on July 1, 2023.

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