

SUMMARY—Prohibits certain discriminatory designs for prescription drug benefits in health benefit plans. (BDR 57-996)

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

Effect on the State: Yes.

AN ACT relating to health insurance; requiring a percentage of certain policies of health insurance and health care plans which provide coverage for prescription drugs to apply a copayment structure before payment of a deductible; 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 federal law prohibits health insurance and health care plans from designing benefits in ways that discriminate against individuals because of their age, disability or expected length of life. (42 U.S.C. § 18022(b)(4)(B)) **Sections 1, 4, 6, 9, 11, 13, 17, 19, 21 and 22** of this bill require certain public and private policies of insurance and health care plans to: (1) provide, in each level of coverage provided by such policies, that at least 25 percent of those policies apply a copayment before the payment of a deductible to the entire prescription drug benefit; and (2) not




place all prescription drugs within a given class within the highest cost tier provided by the policy or plan.

---

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. An insurer that issues a policy of health insurance which provides coverage for prescription drugs shall:*

*(a) For each  level of coverage provided by a policy of health insurance subject to the provisions of this chapter, ensure that at least 25 percent of such policies apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the insurer; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of health insurance.*



*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by an insurer relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with this section is void.*

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

*1. An insurer that issues a policy of group health insurance which provides coverage for prescription drugs shall:*



*(a) For each level of coverage provided by a policy of group health insurance subject to the provisions of this chapter, ensure that at least 25 percent of such policies apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the insurer; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of group health insurance.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by an insurer relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with this section is void.*

**Sec. 5.** 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 4 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. 6.** Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:



*1. A carrier that issues a health benefit plan which provides coverage for prescription drugs shall:*

*(a) For each level of coverage provided by a health benefit plan subject to the provisions of this chapter, ensure that at least 25 percent of such plans apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the carrier; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the health benefit plan.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a carrier relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the plan or renewal which is in conflict with this section is void.*

**Sec. 7.** 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 6 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. 8.** 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 6 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. 9.** Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A society that issues a benefit contract which provides coverage for prescription drugs shall:*

*(a) For each level of coverage provided by a benefit contract subject to the provisions of this chapter, ensure that at least 25 percent of such benefit contracts apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the society; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the benefit contract.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a society relating to the establishment of a copayment structure are consistent with the purposes of this section.*



*3. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the benefit contract or renewal which is in conflict with this section is void.*

**Sec. 10.** NRS 695A.184 is hereby amended to read as follows:

695A.184 1. Except as otherwise provided in this section, a benefit contract which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:

(a) Had previously been approved for coverage by the society for a medical condition of an insured and the insured's provider of health care determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the insured; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the insured.

2. The provisions of subsection 1 do not:

(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration;

(b) Prohibit:

(1) The society from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the insured or from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~§~~ *subject to the provisions of section 9 of this act;*



(2) A provider of health care from prescribing another drug covered by the benefit 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 benefit contract.

3. Any provision of a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2001, which is in conflict with this section is void.

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

*1. A hospital or medical service corporation that issues a policy of health insurance which provides coverage for prescription drugs shall:*

*(a) For each level of coverage provided by a policy of health insurance subject to the provisions of this chapter, ensure that at least 25 percent of such policies apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the hospital or medical service corporation; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the policy of health insurance.*



*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a hospital or medical service corporation relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal which is in conflict with this section is void.*

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

*1. A health maintenance organization that issues a health care plan which provides coverage for prescription drugs shall:*

*(a) For each level of coverage provided by a health care plan subject to the provisions of this chapter, ensure that at least 25 percent of such plans apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the health maintenance organization; and*



*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the health care plan.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a health maintenance organization relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. An evidence of coverage for a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.*

**Sec. 14.** 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.1735 to 695C.1755, inclusive, 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, 695C.1695, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 *and section 13 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. 15.** 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 ~~to~~ *subject to the provisions of section 13 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. 16.** 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 13 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. 17.** Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for prescription drugs shall:*

*(a) For each level of coverage provided by an evidence of coverage subject to the provisions of this chapter, ensure that at least 25 percent of such evidences of coverage apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the prepaid limited health service organization; and*



*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the evidence of coverage.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a prepaid limited health service organization relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.*

**Sec. 18.** NRS 695F.156 is hereby amended to read as follows:

695F.156 1. Except as otherwise provided in this section, evidence of coverage which provides coverage for prescription drugs must not limit or exclude coverage for a drug if the drug:

(a) Had previously been approved for coverage by the prepaid limited health service organization for a medical condition of an enrollee and the enrollee's provider of health care determines, after conducting a reasonable investigation, that none of the drugs which are otherwise currently approved for coverage are medically appropriate for the enrollee; and

(b) Is appropriately prescribed and considered safe and effective for treating the medical condition of the enrollee.

2. The provisions of subsection 1 do not:



(a) Apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration;

(b) Prohibit:

(1) The organization from charging a deductible, copayment or coinsurance for the provision of benefits for prescription drugs to the enrollee or from establishing, by contract, limitations on the maximum coverage for prescription drugs ~~§~~ *subject to the provisions of section 17 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. 19.** Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A managed care organization that issues a health care plan which provides coverage for prescription drugs shall:*



*(a) For each level of coverage provided by a health care plan subject to the provisions of this chapter, ensure that at least 25 percent of such plans apply a copayment structure before payment of a deductible to the entire drug benefit;*

*(b) Ensure that the copayment structure established pursuant to paragraph (a) is reasonably graduated and proportionately related for all levels of benefits offered by the managed care organization; and*

*(c) Not place all prescription drugs in a given class within the highest cost tier designated in the health care plan.*

*2. The Commissioner shall adopt regulations to carry out the provisions of this section and to ensure that the practices used by a managed care organization relating to the establishment of a copayment structure are consistent with the purposes of this section.*

*3. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or renewal which is in conflict with this section is void.*

**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 20 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 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 4 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. 22.** 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.162, 695G.164,



695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 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. 23.** 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. 24.** This act becomes effective on January 1, 2018.

