SENATE BILL NO. 265–SENATORS CANCELA, SEGERBLOM, ATKINSON, PARKS; CANNIZZARO, DENIS, FARLEY, MANENDO AND WOODHOUSE

MARCH 14, 2017

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to prescription drugs. (BDR 40-809)

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

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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 prescription drugs; requiring the Department of Health and Human Services to compile a list of prescription drugs essential for treating diabetes in this State; requiring the manufacturer of a prescription drug included on the list to reimburse a purchaser for a portion of the price of the drug in certain circumstances; requiring the manufacturer of a prescription drug included on the list to report certain information to the Department; requiring certain nonprofit organizations to report to the Department information concerning contributions received from drug manufacturers; requiring the Department to place certain information on its Internet website; authorizing the Department to impose an administrative penalty in certain circumstances; requiring a private school and an employer to allow a pupil or employee, as applicable, to keep and self-administer certain drugs; requiring an insurer to reimburse an insured for a portion of any deductible, copay or coinsurance paid for certain drugs; requiring an insurer to provide certain notice to insureds; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to compile and post on its Internet website information relating to the prices charged for certain prescription drugs. (NRS 439.915) **Section 6** of this bill requires the Department to compile a list of drugs that the Department determines to be essential for treating diabetes in this State. **Section 6** also requires the manufacturer of a drug included on the list to submit to the Department a list of such drugs for which: (1) the wholesale acquisition cost of the drug exceeds the highest price paid for the drug in certain foreign countries; or (2) the manufacturer increases the wholesale acquisition cost of a drug during a calendar year by more than a prescribed amount. **Section 7** of this bill requires the manufacturer of a prescription drug included on the list to submit to the Department an annual report that contains certain information concerning the cost of the drug. **Section 9** of this bill requires a nonprofit organization that advocates for patients or funds medical research in this State to submit information to the Department concerning contributions that the organization receives from manufacturers of prescription drugs. **Section 12** of this bill requires the Department to compile and place that information on the Internet website maintained by the Department. **Section 13** of this bill provides that the Department is not liable for the omission of information from reports or any incorrect information in the reports. **Section 14** of this bill requires the Department to adopt any necessary regulations concerning the reports. **Section 16** of this bill authorizes the Department to impose an administrative penalty on a manufacturer that fails to submit a required report.

Section 6 also requires a manufacturer to reimburse the purchaser of a drug that is included on the list of essential diabetes drugs compiled by the Department if: (1) the wholesale acquisition cost of the drug exceeds the highest price paid for the drug in certain foreign countries; or (2) the manufacturer increases the wholesale acquisition cost of a drug during a calendar year by more than a prescribed amount. **Sections 25, 26, 29, 32, 33, 35, 38, 40, 42 and 44** of this bill require an insurer, including a state or local governmental entity that insures its employees, that receives such a reimbursement to refund any deductible paid by an insured for the drug in an amount that does not exceed the amount of the reimbursement. **Section 8** of this bill requires the manufacturer of a prescription drug included on the list to notify certain insurers at least 90 days before a planned price increase that is larger than a prescribed amount.

Sections 25, 26, 30, 31, 34, 36, 37, 39, 41 and 43 of this bill require an insurer that uses a formulary, including a state or local governmental entity that insures its employees, to publish before each open enrollment period a notice of any drugs on the list that have been removed from the formulary or will be removed from the formulary during the current plan year or the next plan year. **Sections 25 and 26** also require a state or local governmental entity that insures its employees to provide each insured with notice of whether a formulary is used and, if so, the opportunity to obtain information about the formulary. **Section 26** additionally prohibits the State from limiting or excluding coverage provided to its employees for certain prescription drugs that have previously been approved for coverage.

Under existing law, the Division of Public and Behavioral Health of the Department of Health and Human Services licenses and regulates certain health care facilities and organizations that provide health care. (Chapter 449 of NRS) **Sections 17-24** of this bill require the Division to also license and regulate pharmaceutical sales representatives. **Section 19** of this bill makes it a misdemeanor to practice as a pharmaceutical sales representative in this State without a license. **Section 23** of this bill requires a pharmaceutical sales representative to submit an annual report to the Division containing certain information about his or her activities.

Upon the submission of a written request, existing law requires a public school to allow a pupil who has asthma, anaphylaxis or diabetes to carry and self-administer medication to treat his or her disorder while the pupil is on the grounds of a public school, participating in an activity sponsored by a public school or on a school bus. (NRS 392.425) Willful failure to carry out this requirement is grounds for suspending, demoting, dismissing or refusing to reemploy a teacher or administrator. (NRS 391.750) **Sections 27 and 28** of this bill: (1) impose similar requirements for private schools and employers; and (2) make a willful violation of those requirements a misdemeanor.

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

Section 1. Chapter 439 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. ***"Manufacturer" means a person who derives, produces, prepares, compounds, mixes, cultivates, grows or processes a prescription drug.***

Sec. 3. ***"Pharmacy" means every store or shop licensed by the State Board of Pharmacy where drugs, controlled substances, poisons, medicines or chemicals are stored or possessed, or dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed. The term does not include an institutional pharmacy as defined in NRS 639.0085.***

Sec. 4. ***"Third party" means:***

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS 689A.540, for employees which provides coverage for prescription drugs;

3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

4. Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 5. ***"Wholesale acquisition cost" means the manufacturer's list price for a prescription drug to wholesalers or direct purchasers in the United States, not including any discounts, rebates or reductions in price, as reported in wholesale price guides or other publications of drug pricing data.***

Sec. 6. ***1. The Department shall compile and annually update a list of prescription drugs that the Department determines***

to be essential for treating diabetes in this State. The list must include, without limitation, all forms of insulin and biguanides marketed for sale in this State.

2. If the wholesale acquisition cost of a drug included on the list compiled pursuant to subsection 1 is greater than the foreign price cap for that drug on January 1 of the current calendar year, the manufacturer of the drug shall, upon the submission of a valid claim by a person or entity that purchased the drug in this State, including, without limitation, a patient or third party, reimburse the claimant for the difference between the wholesale acquisition cost and the foreign price cap.

3. If the manufacturer of a drug included on the list compiled pursuant to subsection 1 increases the price of the drug during a calendar year by a percentage that is larger than the percentage increase in the Consumer Price Index, Medical Care Component, for that calendar year, the manufacturer of that drug shall, upon the submission of a valid claim by a person or entity that purchased the drug in this State, including, without limitation, a patient or third party, reimburse the claimant for the difference between the amount of the increased price and the price of the drug at the beginning of the calendar year, multiplied by the percentage increase in the Consumer Price Index, Medical Care Component, for that calendar year.

4. A patient who is covered by a third party and has paid a deductible for a drug for which reimbursement is available pursuant to subsection 2 or 3 may submit a claim for reimbursement pursuant to subsection 2 or 3, as applicable. Except as otherwise provided in paragraph (a), the manufacturer shall, upon the submission of a valid claim by such a patient, reimburse the patient for the amount required by subsection 2 or 3, as applicable, not to exceed the amount of the deductible. A manufacturer:

(a) Is not required to provide a reimbursement pursuant to this subsection if the third party that covers the patient submitted a valid claim for reimbursement before the patient submitted his or her claim for reimbursement; and

(b) May deduct the amount of any reimbursement provided to a patient in accordance with this subsection from the amount reimbursed to the third party that covers the patient on a subsequent claim.

5. Each manufacturer of a drug included on the list compiled pursuant to subsection 1 shall :

(a) Establish a means by which a person or entity that purchased the drug in this State may submit a claim for reimbursement pursuant to subsection 2 or 3.

(b) Post conspicuously on an Internet website maintained by the manufacturer and submit to the Department a list of all drugs manufactured by the manufacturer for which reimbursement is available for sales within the immediately preceding 12 months. The list must be updated at least quarterly.

6. As used in this section, "foreign price cap" means the highest price paid for a prescription drug, excluding taxes, in any country other than the United States that is:

(a) A member of the Organisation for Economic Co-operation and Development or its successor organization; or

(b) If the Organisation for Economic Co-operation and Development ceases to exist and has no successor organization, on a list of 35 economically developed countries adopted by regulation of the Department for the purposes of this section.

Sec. 7. *On or before May 1 of each year, the manufacturer of a prescription drug that appears on the list compiled by the Department pursuant to section 6 of this act shall prepare and submit to the Department, in the form prescribed by the Department, a report which must include:*

1. The total cost of research and development for the drug, including, without limitation:

(a) The total cost of any study drug manufactured for the purpose of obtaining approval by the United States Food and Drug Administration of the drug that is the subject of the report;

(b) The total cost of any preclinical studies of the drug;

(c) The total cost of any clinical studies of the drug, including clinical trials performed for the purpose of obtaining the approval of the United States Food and Drug Administration and clinical studies conducted after the drug was approved by the United States Food and Drug Administration, regardless of whether such trials were required by the United States Food and Drug Administration;

(d) The total cost associated with preparing and submitting documents to the United States Food and Drug Administration concerning the drug;

(e) Any cost for research and development incurred with respect to the drug by a predecessor entity of the manufacturer; and

(f) The total cost of studies conducted after the drug was approved by the United States Food and Drug Administration using external providers of data for the purpose of publication;

2. Any other costs of producing the drug, including:

(a) The total cost for materials, manufacturing and administrative expenditures relating to the drug;

(b) The total cost paid by any entity other than the manufacturer or a predecessor entity of the manufacturer for research and development, including money from governmental entities, subsidies and private grants; and

(c) Any cost to acquire rights to the drug, including the cost of purchasing patents or licensing or acquiring a corporate entity that owns rights to the drug;

3. The total administrative expenditures relating to the drug, including marketing and advertising costs;

4. The profit that the manufacturer has earned from the drug and the percentage of the manufacturer's total profit attributable to the drug;

5. The total amount of financial assistance that the manufacturer has provided through any patient prescription assistance program;

6. The cost associated with coupons provided directly to consumers and the cost to the manufacturer attributable to the redemption of those coupons;

7. The wholesale acquisition cost of the drug; and

8. A history of any increases in the wholesale acquisition cost of the drug over the 5 years immediately preceding the date on which the report is submitted, including the amount of each such increase expressed as a percentage of the total wholesale acquisition cost of the drug, the month and year in which each increase became effective and any explanation for the increase.

Sec. 8. ***1. At least 90 days before increasing the wholesale acquisition cost of a prescription drug included on the list compiled pursuant to section 6 of this act by a percentage larger than the percentage increase in the Consumer Price Index, Medical Care Component, for the 12 months immediately preceding the date by which notification is required pursuant to this section, the manufacturer of the drug shall notify each third party listed in the database established pursuant to subsection 2 of the planned price increase.***

2. The Department, in consultation with the Commissioner of Insurance, shall:

(a) Establish and maintain a database of third parties that provide or offer coverage of prescription drugs to residents of this State.

(b) Provide information in that database to a manufacturer upon request for the purposes of complying with the requirements of this section.

Sec. 9. ***On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a contribution from a***

manufacturer during the immediately preceding calendar year shall submit to the Department a report which includes:

1. For each such contribution, the amount of the contribution and the manufacturer that made the contribution; and

2. For each manufacturer that made such a contribution, the percentage of the total gross income of the organization during the immediately preceding calendar year attributable to contributions from the manufacturer.

Sec. 10. NRS 439.150 is hereby amended to read as follows:

439.150 1. The State Board of Health is hereby declared to be supreme in all nonadministrative health matters. It has general supervision over all matters, except for administrative matters and as otherwise provided in NRS 439.950 to 439.983, inclusive, relating to the preservation of the health and lives of citizens of this State and over the work of the Chief Medical Officer and all district, county and city health departments, boards of health and health officers.

2. The Department is hereby designated as the agency of this State to cooperate with the federal authorities in the administration of those parts of the Social Security Act which relate to the general promotion of public health. It may receive and expend all money made available to the Division by the Federal Government, the State of Nevada or its political subdivisions, or from any other source, for the purposes provided in this chapter. In developing and revising any state plan in connection with federal assistance for health programs, the Department shall consider, without limitation, the amount of money available from the Federal Government for those programs, the conditions attached to the acceptance of that money and the limitations of legislative appropriations for those programs.

3. Except as otherwise provided in NRS 576.128 ~~[,]~~ ***and section 19 of this act,*** the State Board of Health may set reasonable fees for the:

(a) Licensing, registering, certifying, inspecting or granting of permits for any facility, establishment or service regulated by the Division;

(b) Programs and services of the Division;

(c) Review of plans; and

(d) Certification and licensing of personnel.

➥ Fees set pursuant to this subsection must be calculated to produce for that period the revenue from the fees projected in the budget approved for the Division by the Legislature.

Sec. 11. NRS 439.900 is hereby amended to read as follows:

439.900 As used in NRS 439.900 to 439.940, inclusive, ***and sections 2 to 9, inclusive, of this act,*** unless the context otherwise

requires, ~~["pharmacy" means every store or shop licensed by the State Board of Pharmacy where drugs, controlled substances, poisons, medicines or chemicals are stored or possessed, or dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed. The term does not include an institutional pharmacy as defined in NRS 639.0085.]~~ ***the words and terms defined in sections 2 to 5, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 12. NRS 439.915 is hereby amended to read as follows:

439.915 1. Except as otherwise provided in ~~[subsection]~~ ***subsections*** 2 ~~[,]~~ ***and 3,*** the Department shall:

(a) ~~[Place]~~ ***Compile and place*** or cause to be placed on the Internet website maintained by the Department the information provided by each pharmacy pursuant to NRS 439.910 ~~[,]~~ ***, each manufacturer pursuant to sections 6 and 7 of this act and each nonprofit organization pursuant to section 9 of this act;***

(b) Ensure that the information provided by each pharmacy pursuant to NRS 439.910 ***, each manufacturer pursuant to sections 6 and 7 of this act and each nonprofit organization pursuant to section 9 of this act*** and placed on the Internet website maintained by the Department is organized so that each individual pharmacy ***, manufacturer and nonprofit organization*** has its own separate entry on that website; and

(c) Ensure that the usual and customary price that each pharmacy charges for each prescription drug that is on the list prepared pursuant to NRS 439.905 and that is stocked by the pharmacy:

(1) Is presented on the Internet website maintained by the Department in a manner which complies with the requirements of NRS 439.920; and

(2) Is updated not less frequently than once each calendar quarter.

➥ Nothing in this subsection prohibits the Department from determining the usual and customary price that a pharmacy charges for a prescription drug by extracting or otherwise obtaining such information from claims reported by pharmacies to the Medicaid program.

2. If a pharmacy is part of a larger company or corporation or a chain of pharmacies or retail stores, the Department may present the pricing information pertaining to such a pharmacy in such a manner that the pricing information is combined with the pricing information relative to other pharmacies that are part of the same company, corporation or chain, to the extent that the pricing information does not differ among those pharmacies.

3. ***The Department is not required to place information reported by a manufacturer pursuant to section 7 of this act on the Internet website maintained by the Department if the Department determines that publishing the information would be detrimental to the financial or competitive position of the manufacturer.***

4. The Department may establish additional or alternative procedures by which a consumer who is unable to access the Internet or is otherwise unable to receive the information described in subsection 1 in the manner in which it is presented by the Department may obtain that information:

(a) In the form of paper records;

(b) Through the use of a telephonic system; or

(c) Using other methods or technologies designed specifically to assist consumers who are hearing impaired or visually impaired.

~~[4.]~~ ***5.*** As used in this section, "usual and customary price" means the usual and customary charges that a ~~[provider]~~ ***pharmacy*** charges to the general public for a drug, as described in 42 C.F.R. § ~~[447.331.]~~ ***447.512.***

Sec. 13. NRS 439.925 is hereby amended to read as follows:

439.925 The Department and its members, officers and employees are not liable civilly or criminally for any act, omission, error or technical problem that results in:

1. The failure to provide to consumers information regarding a pharmacy, ***prescription drug or nonprofit organization,*** including, without limitation, the prices charged by the pharmacy for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905 ~~[;]~~ ***, any information concerning a prescription drug that is required to be reported pursuant to section 6 or 7 of this act or any information that a nonprofit organization is required to report by section 9 of this act;*** or

2. The providing to consumers of incorrect information regarding a pharmacy, ***prescription drug or nonprofit organization,*** including, without limitation, the prices charged by the pharmacy for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905 ~~[.]~~ ***, any information concerning a prescription drug that is required to be reported pursuant to section 6 or 7 of this act or any information that a nonprofit organization is required to report by section 9 of this act.***

Sec. 14. NRS 439.930 is hereby amended to read as follows:

439.930 The Department shall adopt such regulations as it determines to be necessary or advisable to carry out the provisions of NRS 439.900 to 439.940, inclusive ~~[.]~~ ***, and sections 2 to 9, inclusive, of this act.*** Such regulations must provide for, without limitation:

1. Notice to consumers stating that:

(a) Although the Department will strive to ensure that consumers receive accurate information regarding pharmacies, ***prescription drugs and nonprofit organizations,*** including, without limitation, the prices charged by ~~[those]~~ pharmacies for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905, ***the information that is reported concerning prescription drugs pursuant to sections 6 and 7 of this act and the information that is reported by nonprofit organizations pursuant to section 9 of this act,*** the Department is unable to guarantee the accuracy of such information;

(b) If a consumer follows an Internet link from the Internet website maintained by the Department to an Internet website ***not*** maintained by ~~[a pharmacy,]~~ the Department ***, the Department*** is unable to guarantee the accuracy of any information made available on ~~[the Internet]~~ ***that*** website ***;*** ~~[maintained by the pharmacy;]~~ and

(c) The Department advises consumers to contact a pharmacy ***, manufacturer or nonprofit organization*** directly to verify the accuracy of any information regarding the pharmacy ***, a prescription drug manufactured by the manufacturer or the nonprofit organization, as applicable,*** which is made available to consumers pursuant to NRS 439.900 to 439.940, inclusive ~~[,]~~ ***, and sections 2 to 9, inclusive, of this act;***

2. Procedures adopted to direct consumers who have questions regarding the program described in NRS 439.900 to 439.940, inclusive, ***and sections 2 to 9, inclusive, of this act*** to contact the Office for Consumer Health Assistance of the Department;

3. Provisions in accordance with which the Department will allow an Internet link to the information provided by each pharmacy pursuant to NRS 439.910 ***, each manufacturer pursuant to sections 6 and 7 of this act and each nonprofit organization pursuant to section 9 of this act*** and made available on the Department's Internet website to be placed on other Internet websites managed or maintained by other persons and entities, including, without limitation, Internet websites managed or maintained by:

(a) Other governmental entities, including, without limitation, the State Board of Pharmacy and the Office of the Governor; and

(b) Nonprofit organizations and advocacy groups;

4. Procedures pursuant to which consumers ***,*** ~~[and]~~ pharmacies ***, manufacturers and nonprofit organizations*** may report to the Department that information made available to consumers pursuant to NRS 439.900 to 439.940, inclusive, ***and sections 2 to 9, inclusive, of this act*** is inaccurate;

5. The form and manner in which pharmacies are to provide to the Department the information described in NRS 439.910; ~~[and]~~

6. ***The form and manner in which manufacturers are to provide to the Department the information described in sections 6 and 7 of this act;***

7. The form and manner in which nonprofit organizations are to provide to the Department the information described in section 9 of this act; and

8. Standards and criteria pursuant to which the Department may remove from its Internet website information regarding a pharmacy or an Internet link to the Internet website maintained by a pharmacy, or both, if the Department determines that the pharmacy has:

(a) Ceased to be licensed and in good standing pursuant to chapter 639 of NRS; or

(b) Engaged in a pattern of providing to consumers information that is false or would be misleading to reasonably informed persons.

Sec. 15. NRS 439.935 is hereby amended to read as follows:

439.935 1. On or before July 1 of each odd-numbered year, the Department shall make a determination of whether sufficient money is available and authorized for expenditure to fund one or more components of the programs and other duties of the Department relating to NRS 439.900 to 439.940, inclusive ~~[.]~~ ***, and sections 2 to 9, inclusive, of this act.***

2. The Department shall temporarily suspend any components of the program or duties of the Department for which it determines pursuant to subsection 1 that sufficient money is not available.

3. The Department may apply for and accept any available grants and may accept any bequests, devises, donations or gifts from any public or private source to carry out the provisions of NRS 439.900 to 439.940, inclusive ~~[.]~~ ***, and sections 2 to 9, inclusive, of this act.***

Sec. 16. NRS 439.940 is hereby amended to read as follows:

439.940 ***1.*** If a pharmacy that is licensed under the provisions of chapter 639 of NRS and is located within the State of Nevada fails to provide to the Department the information required to be provided pursuant to NRS 439.910 or fails to provide such information on a timely basis, and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department may impose against the pharmacy an administrative penalty of not more than $500 for each day of such failure.

2. If a manufacturer fails to provide to the Department the information required by section 6 or 7 of this act, a nonprofit organization fails to provide to the Department the information required by section 9 of this act or a manufacturer or nonprofit organization fails to provide such information on a timely basis,

and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department may impose against the manufacturer or nonprofit organization, as applicable, an administrative penalty of not more than $5,000 for each day of such failure.

3. If a manufacturer fails to comply with any other requirement of section 6 of this act, the Department may impose against the manufacturer an administrative penalty prescribed by regulation of the Department.

Sec. 17. Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 18 to 24, inclusive, of this act.

Sec. 18. ***As used in sections 18 to 24, inclusive, of this act, unless the context otherwise requires, "pharmaceutical sales representative" means a person who markets prescription drugs to providers of health care in this State.***

Sec. 19. ***1. A person shall not practice as a pharmaceutical sales representative in this State for more than 15 days in any calendar year unless the person holds a valid license as a pharmaceutical sales representative issued by the Division. Such a license expires 1 year after the date on which the license is issued. A person who violates the requirements of this subsection is guilty of a misdemeanor.***

2. The Board shall adopt regulations to carry out the provisions of sections 18 to 24, inclusive, of this act. Those regulations must establish, without limitation:

(a) The qualifications for obtaining or renewing a license as a pharmaceutical sales representative, which must include a requirement that a pharmaceutical sales representative obtain at least 5 hours of continuing education each year concerning ethics, pharmacology or the laws and regulations concerning the marketing of prescription drugs.

(b) The requirements to apply for or renew a license as a pharmaceutical sales representative. No fee may be charged to apply for, reinstate or renew such a license.

(c) Standards of practice for pharmaceutical sales representatives.

(d) Disciplinary action that may be imposed for violating the standards of practice established pursuant to paragraph (c), which may include, without limitation, the suspension or revocation of a license and the imposition of an administrative penalty of not more than $3,000 for each day on which a violation occurs.

(e) Procedures for imposing disciplinary action.

3. A pharmaceutical sales representative shall not:

(a) Engage in deceptive or misleading marketing;

(b) Falsely represent that he or she is licensed or certified as a provider of health care; or

(c) Attend an examination of a patient by a provider of health care without the consent of the patient.

Sec. 20. *An application for the issuance of a license as a pharmaceutical sales representative pursuant to section 19 of this act must include the social security number of the applicant.*

Sec. 21. *1. An applicant for the issuance or renewal of a license as a pharmaceutical sales representative must submit to the Division of Public and Behavioral Health the statement prescribed by the Division of Welfare and Supportive Services of the Department pursuant to NRS 425.520. The statement must be completed and signed by the applicant.*

2. The Division of Public and Behavioral Health shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the certificate; or

(b) A separate form prescribed by the Division.

3. A license as a pharmaceutical sales representative may not be issued or renewed by the Division if the applicant:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Division shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

Sec. 22. *1. If the Division receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational licenses, certificates and permits issued to a person who is the holder of a license as a pharmaceutical sales representative, the Division shall deem the certificate issued to that person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Division receives a letter issued to the holder of*

the certificate by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the certificate has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

2. The Division shall reinstate a license as a pharmaceutical sales representative that has been suspended by a district court pursuant to NRS 425.540 if the Division receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the person whose certificate was suspended stating that the person whose certificate was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

Sec. 23. *1. When a pharmaceutical sales representative submits an application to renew his or her license, he or she shall also submit to the Division a report, which must include, for the immediately preceding year:*

(a) A list of providers of health care whom the pharmaceutical sales representative contacted and the number of times that the pharmaceutical sales representative contacted each provider;

(b) The name, manufacturer and wholesale acquisition cost of each prescription drug marketed by the pharmaceutical sales representative;

(c) The name and manufacturer of each prescription drug for which the pharmaceutical sales representative provided a free sample, the name of each provider of health care to whom a free sample was provided and the number of free samples provided to each such provider; and

(d) The name of each provider of health care to whom the pharmaceutical sales representative provided compensation, including, without limitation, gifts, food or free supplies, and the value of such compensation.

2. As used in this section, "wholesale acquisition cost" has the meaning ascribed to it in section 5 of this act.

Sec. 24. *1. In addition to any other requirements set forth in sections 18 to 24, inclusive, of this act, an applicant for the renewal of a license as a pharmaceutical sales representative must indicate in the application submitted to the Division whether the applicant has a state business registration. If the applicant has a state business registration, the applicant must include in the application the business identification number assigned by the Secretary of State upon compliance with the provisions of chapter 76 of NRS.*

2. The license of a pharmaceutical sales representative may not be renewed if:

(a) The applicant fails to submit the information required by subsection 1; or

(b) The State Controller has informed the Division pursuant to subsection 5 of NRS 353C.1965 that the applicant owes a debt to an agency that has been assigned to the State Controller for collection and the applicant has not:

(1) Satisfied the debt;

(2) Entered into an agreement for the payment of the debt pursuant to NRS 353C.130; or

(3) Demonstrated that the debt is not valid.

3. As used in this section:

(a) "Agency" has the meaning ascribed to it in NRS 353C.020.

(b) "Debt" has the meaning ascribed to it in NRS 353C.040.

Sec. 25. 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.0283,*** 689B.030 to 689B.050, inclusive, 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. 26. 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,]~~ ***to*** 695G.167, ***inclusive,*** 695G.170 to 695G.173, inclusive, 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. 27. Chapter 394 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The parent or legal guardian of a pupil who has asthma, anaphylaxis or diabetes may submit a written request to the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled to allow the pupil to self-administer medication for the treatment of the pupil's asthma, anaphylaxis or diabetes while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus.

2. A private school shall establish protocols for containing blood-borne pathogens and the handling and disposal of needles, medical devices and other medical waste and provide a copy of these protocols and procedures to the parent or guardian of a pupil who requests permission for the pupil to self-administer medication pursuant to subsection 1.

3. A written request made pursuant to subsection 1 must include:

(a) A signed statement of a physician indicating that the pupil has asthma, anaphylaxis or diabetes and is capable of self-administration of the medication while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus;

(b) A written treatment plan prepared by the physician pursuant to which the pupil will manage his or her asthma, anaphylaxis or diabetes if the pupil experiences an asthmatic attack, anaphylactic shock or diabetic episode while on the

grounds of the private school, participating in an activity sponsored by the private school or on a school bus; and

(c) A signed statement of the parent or legal guardian:

(1) Indicating that the parent or legal guardian grants permission for the pupil to self-administer the medication while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus;

(2) Acknowledging that the parent or legal guardian is aware of and understands the provisions of subsections 4 and 5;

(3) Acknowledging the receipt of the protocols provided pursuant to subsection 2;

(4) Acknowledging that the protocols established pursuant to subsection 2 have been explained to the pupil who will self-administer the medication and that he or she has agreed to comply with the protocols; and

(5) Acknowledging that authorization to self-administer medication pursuant to this section may be revoked if the pupil fails to comply with the protocols established pursuant to subsection 2.

4. The provisions of this section do not create a duty for the private school in which the pupil is enrolled, or an employee or agent thereof, that is in addition to those duties otherwise required in the course of service or employment.

5. If a pupil is granted authorization pursuant to this section to self-administer medication, the governing body of the private school in which the pupil is enrolled, the private school and any employee or agent thereof, are immune from liability for the injury to or death of:

(a) The pupil as a result of self-administration of a medication pursuant to this section or the failure of the pupil to self-administer such a medication; and

(b) Any other person as a result of exposure to or injury caused by needles, medical devices or other medical waste from the self-administration of medication by a pupil pursuant to this section.

6. Upon receipt of a request that complies with subsection 3, the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled shall provide written authorization for the pupil to carry and self-administer medication to treat his or her asthma, anaphylaxis or diabetes while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus. The written authorization must be filed with the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled and must include:

(a) The name and purpose of the medication which the pupil is authorized to self-administer;

(b) The prescribed dosage and the duration of the prescription;

(c) The times or circumstances, or both, during which the medication is required or recommended for self-administration;

(d) The side effects that may occur from an administration of the medication;

(e) The name and telephone number of the pupil's physician and the name and telephone number of the person to contact in the case of a medical emergency concerning the pupil; and

(f) The procedures for the handling and disposal of needles, medical devices and other medical waste.

7. The written authorization provided pursuant to subsection 6 is valid for 1 school year. If a parent or legal guardian submits a written request that complies with subsection 3, the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled shall renew and, if necessary, revise the written authorization.

8. If a parent or legal guardian of a pupil who is authorized pursuant to this section to carry medication on his or her person provides to the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled doses of the medication in addition to the dosage that the pupil carries on his or her person, the principal or, if applicable, the school nurse shall ensure that the additional medication is:

(a) Stored on the premises of the private school in a location that is secure; and

(b) Readily available if the pupil experiences an asthmatic attack, anaphylactic shock or diabetic episode during school hours.

9. An employee of a private school who willfully violates any provision of this section is guilty of a misdemeanor.

10. As used in this section:

(a) "Medication" has the meaning ascribed to it in NRS 392.425.

(b) "Physician" has the meaning ascribed to it in NRS 392.425.

(c) "Self-administer" has the meaning ascribed to it in NRS 392.425.

Sec. 28. Chapter 613 of NRS is hereby amended by adding thereto a new section to read as follows:

1. An employee who has asthma, anaphylaxis or diabetes may submit a written request to his or her employer to allow the employee to self-administer medication for the treatment of the employee's asthma, anaphylaxis or diabetes while the employee is

at his or her place of employment or engaged in activities required by his or her employment.

2. A written request made pursuant to subsection 1 must include a signed statement of a physician indicating that the employee has asthma, anaphylaxis or diabetes and is capable of self-administration of the medication while the employee is at his or her place of employment or engaged in activities required by his or her employment.

3. The provisions of this section do not create a duty for the employer that is in addition to those duties otherwise required of the employer.

4. If an employee is granted authorization pursuant to this section to self-administer medication, the employer is immune from liability for the injury to or death of:

(a) The employee as a result of self-administration of a medication pursuant to this section or the failure of the employee to self-administer such a medication; and

(b) Any other person as a result of exposure to or injury caused by needles, medical devices or other medical waste from the self-administration of medication by an employee pursuant to this section.

5. Upon receipt of a request that complies with subsection 1, the employer shall provide written authorization for the employee to carry and self-administer medication to treat his or her asthma, anaphylaxis or diabetes while the employee is at his or her place of employment or engaged in activities required by his or her employment. The written authorization must be maintained in the records of the employer and must include:

(a) The name and purpose of the medication which the employee is authorized to self-administer;

(b) The prescribed dosage and the duration of the prescription;

(c) The times or circumstances, or both, during which the medication is required or recommended for self-administration;

(d) The side effects that may occur from an administration of the medication; and

(e) The name and telephone number of the employee's physician and the name and telephone number of the person to contact in the case of a medical emergency concerning the employee.

6. An employer who willfully violates any provision of this section is guilty of a misdemeanor.

7. As used in this section:

(a) "Medication" has the meaning ascribed to it in NRS 392.425.

(b) "Physician" has the meaning ascribed to it in NRS 392.425.

(c) "Self-administer" has the meaning ascribed to it in NRS 392.425.

Sec. 29. 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 ~~[,]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, an insurer that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. An insurer is not required to reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the insurer submitted its claim for reimbursement.***

4. Any provision of a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 30. 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) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the insurer and accessible to the public 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 section 6 of this act; 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.

Sec. 31. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the insurer and accessible to the public 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 section 6 of this act; 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.

Sec. 32. 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 ~~[,]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, an insurer that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount***

of the deductible, whichever is less. An insurer is not required to reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the insurer submitted its claim for reimbursement.

4. Any provision of a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 33. 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 ~~[;]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, a carrier that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. A carrier is not required to reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of***

section 6 of this act before the insurer submitted its claim for reimbursement.

4. 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 ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 34. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the carrier and accessible to the public 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 section 6 of this act; 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.

Sec. 35. 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 ~~[,]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, a society that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. A society is not required to***

reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the insurer submitted its claim for reimbursement.

4. Any provision of a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 36. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the society and accessible to the public 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 section 6 of this act; 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.

Sec. 37. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the insurer and accessible to the public 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 section 6 of this act; 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.

Sec. 38. 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 ~~[.]~~ ***that comply with the provisions of subsection 3;***

(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. Except as otherwise provided in this subsection, an insurer that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. An insurer is not required to reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the insurer submitted its claim for reimbursement.

4. 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 ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 39. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the health maintenance organization or insurer and accessible to the public 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 section 6 of this act; 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.

Sec. 40. 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 ~~[,]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, a health maintenance organization or insurer that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an enrollee for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible whichever is less. A health maintenance organization or insurer is not required to reimburse an enrollee for any amount for which the enrollee submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the health maintenance organization or insurer submitted its claim for reimbursement.***

4. 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 ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 41. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the prepaid limited health service organization and accessible to the public 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 section 6 of this act; 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.

Sec. 42. 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 ~~[;]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, a prepaid limited health service organization that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an enrollee for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. A prepaid limited health service organization is not required to reimburse an enrollee for any amount for which the enrollee submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the prepaid limited health service organization submitted its claim for reimbursement.***

4. 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 ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 43. 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.

(c) At least 30 days before each period for open enrollment, publish on an Internet website that is operated by the managed care organization and accessible to the public 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 section 6 of this act; 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.

Sec. 44. 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 ~~[;]~~ ***that comply with the provisions of subsection 3;***

(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. ***Except as otherwise provided in this subsection, a managed care organization that receives a reimbursement from the manufacturer of a prescription drug pursuant to section 6 of this act shall refund any deductible paid by an insured for the prescription drug in an amount equal to the amount of the reimbursement or the amount of the deductible, whichever is less. A managed care organization is not required to reimburse an insured for any amount for which the insured submitted a claim for reimbursement pursuant to subsection 4 of section 6 of this act before the managed care organization submitted its claim for reimbursement.***

4. 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 ***:***

(a) October 1, 2001, which is in conflict with ~~[this section]~~ ***subsection 1*** is void.

(b) January 1, 2018, which is in conflict with subsection 3 is void.

Sec. 45. 1. This section becomes effective upon passage and approval.

2. Sections 27 and 28 of this act become effective on July 1, 2017.

3. Sections 1 to 26, inclusive, and 29 to 44, inclusive, of this act become effective upon passage and approval for the purpose of adopting regulations and performing any other administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2018, for all other purposes.

4. Sections 20, 21 and 22 of this act expire by limitation on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.

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