

Assembly Bill No. 434—Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to prescription drugs; prohibiting certain pharmacy benefit managers and health carriers from taking certain actions against entities that participate in a federal program to facilitate the discounted purchase of prescription drugs; prohibiting a program administered by the Department of Health and Human Services to provide therapeutics to persons with human immunodeficiency virus from taking similar actions; imposing certain limitations on the use of money available to administer the program to provide therapeutics to persons with human immunodeficiency virus; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing federal law creates a program, known as the 340B Program, by which certain hospitals and other facilities that provide health care to low-income patients are able to purchase certain drugs at discounted rates. (42 U.S.C. § 256b) Existing law prohibits a pharmacy benefit manager from prohibiting a pharmacist or pharmacy from taking certain actions to assist a person in obtaining a less expensive alternative or generic drug. (NRS 683A.179) Existing law imposes certain requirements relating to the operation of health carriers. (NRS 687B.470-687B.850) **Sections 1, 3, 6 and 7** of this bill prohibit pharmacy benefit managers and health carriers, including governmental entities that provide coverage for employees, from: (1) discriminating against a covered entity that participates in the 340B Program to purchase drugs at a discounted rate or a pharmacy that contracts with such an entity with regard to reimbursement; (2) taking certain actions to limit the ability of such an entity or pharmacy to receive the full benefit of participating in that program; (3) excluding such an entity or pharmacy from an insurance network because the entity or pharmacy participates in that program; (4) restricting the ability of a person to receive a 340B drug; or (5) taking certain other actions to limit the participation of an entity or pharmacy in the Program. **Section 1** exempts from those prohibitions a pharmacy benefit manager that manages prescription drug benefits under Medicaid. **Sections 1 and 3** also provide that the provisions of those sections do not prohibit the Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department of Health and Human Services or a Medicaid managed care organization from taking certain actions necessary to comply with federal law or ensure the financial stability of the Medicaid program. **Sections 2, 4 and 5** of this bill make conforming changes to indicate the proper placement of **sections 1 and 3** in the Nevada Revised Statutes.

Existing law authorizes the Department of Health and Human Services to administer a program pursuant to federal law to provide therapeutics to treat certain persons who have been diagnosed with the human immunodeficiency virus. (NRS 439.529) **Section 9** of this bill prescribes certain limitations on the use of money allocated to the program. **Section 8** of this bill requires the program to take certain actions and refrain from certain activity to ensure that a covered provider that participates in the 340B Program to purchase drugs at a discounted rate or a pharmacy that contracts with such a provider receives the full benefit of participating in the Program. **Section 8** additionally prohibits the program



administered by the Department from: (1) denying a request from such a covered provider or contract pharmacy to participate in the network of the program in certain circumstances; or (2) engaging in certain discrimination against a covered provider or contract pharmacy.

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

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

Section 1. Chapter 683A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A pharmacy benefit manager shall not:

(a) Discriminate against a covered entity, a contract pharmacy or a 340B drug in the amount of reimbursement for any item or service or the procedures for obtaining such reimbursement;

(b) Assess any fee, chargeback, clawback or adjustment against a covered entity or contract pharmacy on the basis that the covered entity or contract pharmacy dispenses a 340B drug or otherwise limit the ability of a covered entity or contract pharmacy to receive the full benefit of purchasing the 340B drug at or below the ceiling price, as calculated pursuant to 42 U.S.C. § 256b(a)(1);

(c) Exclude a covered entity or contract pharmacy from any network because the covered entity or contract pharmacy dispenses a 340B drug;

(d) Restrict the ability of a person to receive a 340B drug, including, without limitation, by imposing a copayment, coinsurance, deductible or other cost-sharing obligation on the drug that is different from a similar drug on the basis that the drug is a 340B drug;

(e) Restrict the methods by which a covered entity or contract pharmacy may dispense or deliver a 340B drug or the entity through which a covered entity may dispense or deliver such a drug in a manner that does not apply to drugs that are not 340B drugs; or

(f) Prohibit a covered entity or contract pharmacy from purchasing a 340B drug or interfere with the ability of a covered entity or contract pharmacy to purchase a 340B drug.

2. This section does not:

(a) Apply to a pharmacy benefit manager that has entered into a contract with the Department of Health and Human Services pursuant to NRS 422.4053 when the pharmacy benefit manager is managing prescription drug benefits under Medicaid, including,



without limitation, where such benefits are delivered through a Medicaid managed care organization.

(b) Prohibit the Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department of Health and Human Services or a Medicaid managed care organization from taking such actions as are necessary to:

(1) Prevent duplicate discounts or rebates where prohibited by 42 U.S.C. § 256b(a)(5)(A); or

(2) Ensure the financial stability of the Medicaid program, including, without limitation, by including or enforcing provisions in any contract with a pharmacy benefit manager entered into pursuant to NRS 422.4053.

3. As used in this section:

(a) "340B drug" means a prescription drug that is purchased by a covered entity under the 340B Program.

(b) "340B Program" means the drug pricing program established by the United States Secretary of Health and Human Services pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended.

(c) "Contract pharmacy" means a pharmacy that enters into a contract with a covered entity to dispense 340B drugs and provide related pharmacy services to the patients of the covered entity.

(d) "Covered entity" has the meaning ascribed to it in 42 U.S.C. § 256b(a)(4).

(e) "Medicaid managed care organization" has the meaning ascribed to it in 42 U.S.C. § 1396b(m).

(f) "Network" means a defined set of providers of health care who are under contract with a pharmacy benefit manager or third party to provide health care services to covered persons.

Sec. 2. NRS 683A.171 is hereby amended to read as follows:

683A.171 As used in NRS 683A.171 to 683A.179, inclusive, *and section 1 of this act*, unless the context otherwise requires, the words and terms defined in NRS 683A.172 to 683A.176, inclusive, have the meanings ascribed to them in those sections.

Sec. 3. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health carrier shall not:

(a) Discriminate against a covered entity, a contract pharmacy or a 340B drug in the amount of reimbursement for any item or service or the procedures for obtaining such reimbursement;

(b) Assess any fee, chargeback, clawback or adjustment against a covered entity or contract pharmacy on the basis that the



covered entity or contract pharmacy dispenses a 340B drug or otherwise limit the ability of a covered entity or contract pharmacy to receive the full benefit of purchasing the 340B drug at or below the ceiling price, as calculated pursuant to 42 U.S.C. § 256b(a)(1);

(c) Exclude a covered entity or contract pharmacy from any network because the covered entity or contract pharmacy dispenses a 340B drug;

(d) Restrict the ability of a person to receive a 340B drug, including, without limitation, by imposing a copayment, coinsurance, deductible or other cost-sharing obligation on the drug that is different from a similar drug on the basis that the drug is a 340B drug;

(e) Restrict the methods by which a covered entity or contract pharmacy may dispense or deliver a 340B drug or the entity through which a covered entity may dispense or deliver such a drug in a manner that does not apply to drugs that are not 340B drugs; or

(f) Prohibit a covered entity or contract pharmacy from purchasing a 340B drug or interfere with the ability of a covered entity or contract pharmacy to purchase a 340B drug.

2. This section does not prohibit the Department of Health and Human Services, the Division of Health Care Financing and Policy of the Department of Health and Human Services or a Medicaid managed care organization from taking such actions as are necessary to:

(a) Prevent duplicate discounts or rebates where prohibited by 42 U.S.C. § 256b(a)(5)(A); or

(b) Ensure the financial stability of the Medicaid program, including, without limitation, by including or enforcing provisions in any relevant contract.

3. As used in this section:

(a) "340B drug" means a prescription drug that is purchased by a covered entity under the 340B Program.

(b) "340B Program" means the drug pricing program established by the United States Secretary of Health and Human Services pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended.

(c) "Contract pharmacy" means a pharmacy that enters into a contract with a covered entity to dispense 340B drugs and provide related pharmacy services to the patients of the covered entity.

(d) "Covered entity" has the meaning ascribed to it in 42 U.S.C. § 256b(a)(4).



(e) "Medicaid managed care organization" has the meaning ascribed to it in 42 U.S.C. § 1396b(m).

Sec. 4. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, *and section 3 of this act*, unless the context otherwise requires, the words and terms defined in NRS 687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those sections.

Sec. 5. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~§~~, *and section 3 of this act*;

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~§~~, *and section 3 of this act*; and

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~§~~, *and section 3 of this act*.

Sec. 6. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation



of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, 689B.265, 689B.287 and 689B.500 *and section 3 of this act* apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.



4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 7. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, *and section 3 of this act*, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 8. Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the Department administers a program pursuant to NRS 439.529:

(a) The program may not prohibit or interfere with the ability of a covered provider or contract pharmacy to purchase, administer or dispense, as applicable, a 340B drug, regardless of whether the drug is dispensed or administered to a person participating in the program or whether the program pays all, part or none of the cost of the drug.



(b) When a covered provider or contract pharmacy dispenses or administers a drug that is eligible to be a 340B drug to a person participating in the program and the program pays the insurance premium of the person and the copayment, coinsurance, deductible or other cost-sharing obligation of the person, the program shall pay to the covered provider or contract pharmacy the full amount of the copayment, coinsurance, deductible or other cost-sharing obligation, regardless of whether the drug is a 340B drug.

(c) The program may not deny a request from a covered provider or contract pharmacy to be included in the network of the program if the covered provider or contract pharmacy:

(1) Meets the terms and conditions for participation in the network of the program; and

(2) Requests to participate in the network of the program.

(d) The program shall not treat a covered provider or contract pharmacy differently from an entity that does not participate in the 340B Program or a pharmacy that has contracted with a covered provider, as applicable, in any manner, including, without limitation:

(1) In any regulation, guidance, policy, procedure or contract;

(2) With regard to participation in the network of the program; or

(3) In any matter relating to the dispensing of drugs or billing and reimbursement for drugs.

2. As used in this section:

(a) "340B drug" means a prescription drug that is purchased under the 340B Program.

(b) "340B Program" means the drug pricing program established by the United States Secretary of Health and Human Services pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended.

(c) "Contract pharmacy" means a pharmacy that enters into a contract with a covered provider to dispense 340B drugs and provide related pharmacy services to the patients of the covered provider.

(d) "Covered entity" has the meaning ascribed to it in 42 U.S.C. § 256b(a)(4).

(e) "Covered provider" means a covered entity other than the program established pursuant to NRS 439.529.

(f) "Network" means a defined set of providers of health care who are under contract with any program established pursuant to



NRS 439.529 to provide health care services to persons who participate in the program.

Sec. 9. NRS 439.529 is hereby amended to read as follows:

439.529 1. The Department may, to the extent that money is available, administer a program pursuant to 42 U.S.C. §§ 300ff-21 et seq. to provide therapeutics to treat certain persons who have been diagnosed with the human immunodeficiency virus and to prevent the serious deterioration of the health of such persons. The program may include the provision of subsidies and pharmaceutical services.

2. The Director shall:

(a) Establish the criteria for eligibility for participation in the program administered pursuant to this section, which must be in accordance with the provisions of 42 U.S.C. §§ 300ff-21 et seq.; and

(b) Prescribe the manner in which the program will be administered and services will be provided.

3. The Department may use any other program administered by the Department to facilitate the provision of subsidies and services pursuant to this section, including, without limitation, the provision of subsidies for pharmaceutical services to senior citizens and persons with disabilities pursuant to NRS 439.635 to 439.690, inclusive. If the Department uses another program to facilitate the provision of subsidies and services pursuant to this section, the Department shall not commingle the money available to carry out the provisions of this section and the money available to carry out the other program.

4. Money available to carry out the provisions of this section must be accounted for separately by the Department. ***The Department shall use such money only to pay for or subsidize the cost of:***

(a) Drugs approved by the United States Food and Drug Administration;

(b) Insurance premiums, deductibles, copayments, coinsurance or other cost-sharing obligations associated with private health insurance; and

(c) Services that improve access to, adherence to and monitoring of drug treatment.

Sec. 10. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 9, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and



(b) On January 1, 2024, for all other purposes.

