SENATE BILL NO. 359–SENATORS PICKARD, HARDY; AND SETTELMEYER

MARCH 19, 2019

JOINT SPONSORS: ASSEMBLYMEN HARDY, KRAMER; EDWARDS, ELLISON, LEAVITT AND ROBERTS

Referred to Committee on Commerce and Labor

SUMMARY—Provides for continued coverage for health care for certain chronic health conditions. (BDR 57-627)

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

CONTAINS UNFUNDED MANDATE (§ 19)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to coverage for health care; requiring an insurer under a policy of health insurance to continue coverage for a procedure, device, medication or other treatment for a chronic condition of an insured under certain circumstances; requiring a provider of health care to examine an insured before altering certain previously approved prescriptions; requiring a provider of health care to cooperate in a timely manner with pharmacists, insurers and pharmacy benefit managers with regard to certain coverage for an insured; limiting the frequency of prescription drug formulary changes; requiring that initial notice to an insured be sent not less than 60 days before a formulary change with a follow-up notice sent not less than 30 days before the formulary change; authorizing the imposition of a civil penalty for certain insurers and pharmacy benefit managers that violate the requirements concerning continued coverage; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law allows insurers, with certain exceptions, to require prior authorization before providing coverage for treatment of a health condition. (NRS 687B.225) **Sections 2-12** of this bill prohibit an insurer from requiring prior authorization or other preconditions for coverage, or from denying coverage for a chronic condition for which approval for coverage had previously been provided either by the present insurer or by the immediately preceding former insurer. **Section 13** of this bill provides certain exemptions from these prohibitions under certain circumstances.

Section 14 of this bill prohibits a health care provider from altering the previously approved prescription for treatment of a chronic condition without first performing an in-person or telehealth examination of the insured. **Section 14** also authorizes the revision of coverage by an insurer or pharmacy benefit manager after providing for an in-person or telehealth examination of the insured by the provider of health care for the insured. **Section 14** also requires that the provider of health care for an insured cooperate in a timely manner with a request from a pharmacist, insurer or pharmacy benefit manager which relates to coverage for a chronic condition of the insured.

Except in certain circumstances, **section 15** of this bill permits an insurer to change a prescription drug formulary to remove a prescription drug not more than twice per plan year. One change is required to coincide with the open enrollment period, if any, and the other may not occur earlier than 6 months after the first such change. **Section 16** of this bill requires an insurer to provide the insured with two notices of changes in the prescription drug formulary, the first not less than 60 days before the effective date of the change and the second not less than 30 days before the effective date of the change. **Section 16** also specifies certain content in the notice and requires the insurer or the pharmacy benefit manager of the insurer to maintain a record that the insured actually received the notices. **Section 17** of this bill authorizes the imposition of a civil penalty for certain insurers and pharmacy benefit managers that violate the provisions of **sections 2-16** of this bill.

Sections 18-20 of this bill make conforming changes to clarify that **sections 2-17** apply for the purposes of coverage for state and local governmental employees.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 17, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 17, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 10, inclusive, of this act, have the meanings ascribed to them in those sections.***

Sec. 3. ***"Chronic condition" means a condition of an insured that is determined by a provider of health care, in the exercise of his or her professional judgment, to be one from which the insured is unlikely to recover or, if applicable, attain remission.***

Sec. 4. ***"Health care services" has the meaning ascribed to it in NRS 695G.022.***

Sec. 5. ***"Insurer" includes, without limitation, a governmental entity which offers, administers or otherwise provides a policy of health insurance.***

Sec. 6. ***"Medicaid" has the meaning ascribed to it in NRS 439B.120.***

Sec. 7. ***"Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.***

Sec. 8. ***"Policy of health insurance" means a policy, contract, certificate, plan or agreement issued pursuant to or governed by chapter 287, 689A, 689B, 689C, 695C, 695F or 695G of NRS for the provision of, delivery of, arrangement for, payment for or reimbursement for any of the costs of health care services. The term includes, without limitation, Medicaid and any other program or plan offered by or through a governmental entity for the provision of, delivery of, arrangement for, payment for or reimbursement for any of the costs of health care services.***

Sec. 9. ***"Provider of health care" means a physician or other health care practitioner who is licensed or otherwise authorized in this State to furnish any health care services.***

Sec. 10. ***"Telehealth" has the meaning ascribed to it in NRS 629.515.***

Sec. 11. ***Except as otherwise provided in section 13 of this act, if an insurer, pursuant to a policy of health insurance, approves coverage for a procedure, device, medication or any other treatment for a condition for an insured, and the provider of health care for the insured determines that the condition of the insured is a chronic condition, the insurer shall not:***

1. Deny continued coverage for the treatment; or

2. Require that the insured obtain prior authorization or fulfill any other preconditions before continuing coverage for the treatment.

Sec. 12. ***The present insurer of an insured must not require approval of the coverage for a procedure, device, medication or any other treatment for a chronic condition of the insured, and for all purposes shall deem the procedure, device, medication or other treatment to be approved if:***

1. The policy of health insurance of the present insurer covers the procedure, device, medication or other treatment;

2. The former insurer from which the insured received coverage immediately preceding the present insurer approved the procedure, device, medication or other treatment;

3. The insured delivers to the present insurer reasonable evidence of the approval from the former insurer as described in subsection 2; and

4. The present insurer does not have credible evidence that the chronic condition does not exist, no longer exists or, if applicable, is in remission.

Sec. 13. ***An insurer subject to the provisions of section 11 or 12 of this act may deny continued coverage or require prior authorization or other precondition for continuing coverage if, before the denial or imposition of the required precondition, the insurer obtains credible evidence that the chronic condition does not exist, no longer exists or, if applicable, is in remission.***

Sec. 14. ***1. The provider of health care for the insured shall not alter the previously approved prescription for a procedure, device, medication or any other treatment for a chronic condition for an insured without first performing an in-person or telehealth examination of the insured.***

2. An insurer or pharmacy benefit manager may revise coverage for a chronic condition of the insured in consultation with the provider of health care for the insured after providing for an in-person or telehealth examination of the insured by the provider of health care for the insured.

3. The provider of health care for the insured shall cooperate in a timely manner with a request from a pharmacist, insurer or pharmacy benefit manager which relates to coverage for a chronic condition of the insured.

Sec. 15. ***1. Except as otherwise provided in subsection 2, an insurer that issues a policy of health insurance that uses a prescription drug formulary may change the formulary to remove a prescription drug not more than twice per plan year. One such change must coincide with the open enrollment period for the policy, if any, and any subsequent change must not occur earlier than 6 months after the first such change.***

2. An insurer may remove a prescription drug from the formulary at any time if the Food and Drug Administration prohibits distribution of the drug or the manufacturer withdraws the drug from the market. The insurer or the pharmacy benefit manager of the insurer shall notify the insureds of the insurer and, if known, the provider of health care of the insureds of the change as soon as practicable.

Sec. 16. ***1. Except as otherwise provided in NRS 687B.408, if a policy of health insurance includes coverage for a procedure, device, medication or any other treatment for a chronic condition of an insured, not less than 60 days before the effective date of a change in the prescription drug formulary that would affect coverage for the condition of the insured, and again not less than 30 days before the effective date of such a change, the insurer or the pharmacy benefit manager of the insurer shall notify the***

insured and, if known, the provider of health care of the insured of the change. The notice must include, without limitation, the effective date of the change, the particular procedure, device, medication or other treatment of the insured that will be affected and the proposed equally effective safe alternative replacement. The notice must also include, without limitation, information advising the insured that he or she may need to consult with his or her provider of health care before the effective date of the change to avoid any interruption in his or her medication or treatment.

2. If the insurer or the pharmacy benefit manager of the insurer fails to provide the notice required pursuant to subsection 1, the insurer must continue to provide coverage to the insured pursuant to section 11 of this act until the insurer properly complies with subsection 1.

3. Each insurer or the pharmacy benefit manager of the insurer shall maintain a record that the insured actually received the notices required pursuant to subsection 1. The record may be an electronic acknowledgment of receipt or in such other form as the Commissioner may require.

Sec. 17. ***An insurer or pharmacy benefit manager which violates any provision of sections 2 to 16, inclusive, of this act and which is not a governmental entity is subject, at the discretion of the Commissioner, to the imposition of a civil penalty of not more than $500 per day for each day the violation continues.***

Sec. 18. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 2 to 17, inclusive, of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 19. NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, and 689B.287 ***and sections 2 to 17, inclusive, of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378 and 689B.03785 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. 20. 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 687B.409, 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 2 to 17, inclusive, 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. 21. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 22. This act becomes effective on July 1, 2019.

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