

Amendment No. 400

Senate Amendment to Senate Bill No. 201	(BDR 54-582)
Proposed by: Senate Committee on Commerce and Labor	
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 201 (§ 7).

ASSEMBLY ACTION			Initial and Date	SENATE ACTION			Initial and Date		
Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____	Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____
Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____
Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____

EXPLANATION: Matter in (1) *blue bold italics* is new language in the original bill; (2) variations of green bold underlining is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

DAN/EWR



Date: 4/21/2023

S.B. No. 201—Revises provisions governing pharmacists. (BDR 54-582)



SENATE BILL NO. 201—SENATORS STONE,
GOICOECHEA AND HANSEN

MARCH 2, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing pharmacists. (BDR 54-582)

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

CONTAINS UNFUNDED MANDATE (§ 7)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

~

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

AN ACT relating to pharmacy; authorizing a pharmacist to engage in certain activity relating to laboratories and laboratory testing; requiring certain insurance plans to cover certain services of pharmacists; requiring health carriers to demonstrate the capacity to adequately deliver such services; imposing certain requirements relating to the participation of pharmacists in a network plan; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

Existing law requires the State Board of Pharmacy to adopt regulations governing the manipulation of a person for the collection of specimens by a pharmacist that: (1) require the pharmacist to use only a fingerstick or oral or nasal swab to collect the specimens; and (2) set forth the procedures and requirements the pharmacist is required to follow when manipulating a person for the collection of a specimen. (NRS 639.0747) **Section 2** of this bill removes the requirement a pharmacist only use a fingerstick or oral or nasal swab to collect a specimen, thereby authorizing a pharmacist to collect a specimen using any method available for the collection of the specimen.

Existing law authorizes a pharmacist to: (1) perform a home blood glucose test; and (2) order and perform laboratory tests that are necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus. (NRS 639.2808, 639.28085) **Section 3** of this bill additionally authorizes a pharmacist to: (1) order laboratory tests that are necessary for any drug therapy or that otherwise facilitate the care of a patient ~~and~~ **within the authorized scope of practice of the pharmacist;** and (2) perform certain other laboratory tests determined by the Federal Government to be simple laboratory examinations and procedures that have an insignificant risk of an erroneous result. **Section 1** of this bill provides that ordering and performing such laboratory tests constitutes the practice of pharmacy. **Section 4** of this bill removes a duplicative provision from existing law.

Existing law requires the State Board of Health to adopt regulations for the certification and licensure of laboratory directors. (NRS 652.125) Existing regulations define an exempt laboratory to be a laboratory that: (1) conducts only certain microscopy tests and tests determined by the Federal Government to be simple laboratory examinations and procedures

24 that have an insignificant risk of an erroneous result; and (2) does not perform only tests for
 25 human immunodeficiency virus. (NAC 652.072) **Section 5** of this bill requires regulations of
 26 the Board to authorize a pharmacist to serve as the director of an exempt laboratory.

27 Existing law requires public and private policies of insurance regulated under Nevada law
 28 to include certain coverage. (NRS 287.010, 287.04335, 422.2717-422.27241, 689A.04033-
 29 689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194-689C.195, 695A.184-
 30 695A.1875, 695B.1901-695B.1948, 695C.1691-695C.176, 695G.162-695G.177) Existing law
 31 requires employers to provide certain benefits to employees, including the coverage required
 32 of health insurers, if the employer provides health benefits for its employees. (NRS 608.1555)
 33 **Sections 7-9, 15, 18, 20, 22, 23, 25, 27, 28 and 31** of this bill require public and private health
 34 plans, including Medicaid and health plans for state and local government employees, to: (1)
 35 provide coverage for services provided by a pharmacist within his or her scope of practice if
 36 such services are covered when performed by another provider of health care; and (2)
 37 reimburse such services at a rate equal to or greater than that provided to a physician,
 38 physician assistant or advanced practice registered nurse for similar services. **Sections 7-9, 12,**
 39 **15, 18, 20, 22, 23, 25, 27, 28 and 31** prohibit such a health plan requiring prior authorization
 40 for such services performed by a pharmacist if prior authorization is not required when the
 41 service is performed by another provider of health care. **Sections 10, 16, 19, 21, 24, 26, 29**
 42 **and 32** of this bill remove duplicative provisions from existing law. **Sections 6 and 17** of this
 43 bill make conforming changes to indicate the proper placement of **sections 9 and 15** in the
 44 Nevada Revised Statutes. **Section 30** of this bill authorizes the Commissioner of Insurance to
 45 suspend or revoke the certificate of a health maintenance organization that fails to comply
 46 with the requirements of **section 27**. The Commissioner would also be authorized to take such
 47 action against other health insurers who fail to comply with the requirements of **sections 15,**
 48 **18, 20, 22, 23, 25 and 31**. (NRS 680A.200)

49 Existing law requires a carrier that offers coverage in the small employer group or
 50 individual market to, before making any network plan available for sale in this State,
 51 demonstrate the capacity to deliver services adequately by applying to the Commissioner for
 52 the issuance of a network plan. (NRS 687B.490) **Sections 7, 8 and 11** of this bill require a
 53 health carrier offering coverage in any market, including health plans for state and local
 54 government employees, to: (1) demonstrate the capacity to adequately deliver the services of
 55 pharmacists to covered persons; (2) accept the credentialing of a pharmacist who is employed
 56 by a health care facility to which the health carrier has delegated the authority to enter into
 57 credentialing agreements; and (3) negotiate in good faith with such a health care facility to
 58 include such pharmacists in the network plan of the health carrier. **Sections 13 and 14** of this
 59 bill make conforming changes to indicate the proper placement of **section 11** in the Nevada
 60 Revised Statutes.

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

1 **Section 1.** NRS 639.0124 is hereby amended to read as follows:

2 639.0124 1. "Practice of pharmacy" includes, but is not limited to, the:

3 (a) Performance or supervision of activities associated with manufacturing,
 4 compounding, labeling, dispensing and distributing of a drug, including the receipt,
 5 handling and storage of prescriptions and other confidential information relating to
 6 patients.

7 (b) Interpretation and evaluation of prescriptions or orders for medicine.

8 (c) Participation in drug evaluation and drug research.

9 (d) Advising of the therapeutic value, reaction, drug interaction, hazard and use
 10 of a drug.

11 (e) Selection of the source, storage and distribution of a drug.

12 (f) Maintenance of proper documentation of the source, storage and
 13 distribution of a drug.

14 (g) Interpretation of clinical data contained in a person's record of medication.

1 (h) Development of written guidelines and protocols in collaboration with a
 2 practitioner which authorize collaborative drug therapy management. The written
 3 guidelines and protocols must comply with NRS 639.2629.

4 (i) Implementation and modification of drug therapy, administering drugs and
 5 ordering and performing tests in accordance with a collaborative practice
 6 agreement.

7 (j) Prescribing, dispensing and administering of drugs for preventing the
 8 acquisition of human immunodeficiency virus and ordering and conducting
 9 laboratory tests necessary for therapy that uses such drugs pursuant to the protocol
 10 prescribed pursuant to NRS 639.28085.

11 (k) Dispensing a self-administered hormonal contraceptive pursuant to NRS
 12 639.28078.

13 *(l) Performing and ordering laboratory tests in accordance with NRS*
 14 *639.2808.*

15 2. The term does not include the changing of a prescription by a pharmacist or
 16 practitioner without the consent of the prescribing practitioner, except as otherwise
 17 provided in NRS 639.2583, 639.28078 and 639.28085.

18 **Sec. 2.** NRS 639.0747 is hereby amended to read as follows:

19 639.0747 ~~[[~~ The Board shall adopt such regulations as are necessary to
 20 carry out the provisions of NRS 652.210 with regard to a registered pharmacist,
 21 including, without limitation, regulations that ~~[[~~

22 ~~—(a) Require a registered pharmacist to use only a fingerstick or oral or nasal~~
 23 ~~swab to collect the specimens pursuant to NRS 652.210; and~~

24 ~~—(b) Set] set~~ forth the procedures and requirements with which a registered
 25 pharmacist shall comply when manipulating a person for the collection of
 26 specimens or performing any laboratory test pursuant to NRS 652.210.

27 ~~[[2.— As used in this section, “fingerstick” means a procedure in which a finger~~
 28 ~~is pricked with a lancet, small blade or other instrument to obtain a small quantity~~
 29 ~~of blood for any laboratory test pursuant to NRS 652.210.]~~

30 **Sec. 3.** NRS 639.2808 is hereby amended to read as follows:

31 639.2808 1. A registered pharmacist ~~for a] may:~~

32 *(a) Order laboratory tests that are necessary for therapy that uses a drug*
 33 *approved by the Food and Drug Administration or to otherwise facilitate the care*
 34 *of a patient ~~[[~~ within the authorized scope of practice of the registered*
 35 *pharmacist; and*

36 *(b) Perform any laboratory test that is classified as a waived test under 42*
 37 *C.F.R. Part 493, Subpart A, including, without limitation, a blood glucose test*
 38 *using devices for monitoring approved by the Food And Drug Administration for*
 39 *use in the home.*

40 2. A registered intern pharmacist may perform a blood glucose test using
 41 devices for monitoring approved by the Food and Drug Administration for use in
 42 the home. The performance of such a test must be in compliance with standards of
 43 practice recommended by the American Association of Diabetes Educators or its
 44 successor organization. *The Board may adopt regulations authorizing a registered*
 45 *intern pharmacist to perform other activities described in subsection 1.*

46 **Sec. 4.** NRS 639.28085 is hereby amended to read as follows:

47 639.28085 1. To the extent authorized by federal law, a pharmacist who
 48 meets the requirements prescribed by the Board pursuant to subsection 2 may, in
 49 accordance with the requirements of the protocol prescribed pursuant to subsection
 50 2:

51 (a) ~~[[Order and perform]] Perform~~ laboratory tests that are necessary for therapy
 52 that uses a drug approved by the United States Food and Drug Administration for
 53 preventing the acquisition of human immunodeficiency virus; and

1 (b) Prescribe, dispense and administer any drug described in paragraph (a) to a
2 patient.

3 2. The Board shall adopt regulations:

4 (a) Requiring a pharmacist who takes the actions authorized by this section to
5 be covered by adequate liability insurance, as determined by the Board; and

6 (b) Establishing a protocol for the actions authorized by this section.

7 **Sec. 5.** NRS 652.125 is hereby amended to read as follows:

8 652.125 1. The Board shall adopt regulations for the certification and
9 licensure of laboratory directors and laboratory personnel who perform technical
10 duties other than the collection of blood. *Those regulations must authorize a
11 registered pharmacist to serve as the director of an exempt laboratory, regardless
12 of whether the registered pharmacist has entered into a collaborative practice
13 agreement.*

14 2. The Division shall, as a prerequisite for the renewal of a certificate or
15 license, require the laboratory director and any laboratory personnel certified by the
16 Division pursuant to this chapter to comply with the requirements for continuing
17 education adopted by the Board.

18 3. *As used in this section:*

19 (a) *“Collaborative practice agreement” has the meaning ascribed to it in
20 NRS 639.0052.*

21 (b) *“Exempt laboratory” means a laboratory:*

22 (1) *That is licensed pursuant to this chapter and the regulations adopted
23 pursuant thereto;*

24 (2) *That does not only perform testing for human immunodeficiency
25 virus; and*

26 (3) *In which each test performed is:*

27 (I) *Classified as a waived test pursuant to 42 C.F.R. Part 493,
28 Subpart A; or*

29 (II) *Categorized as a provider-performed microscopy procedure
30 pursuant to 42 C.F.R. § 493.19.*

31 **Sec. 6.** NRS 232.320 is hereby amended to read as follows:

32 232.320 1. The Director:

33 (a) Shall appoint, with the consent of the Governor, administrators of the
34 divisions of the Department, who are respectively designated as follows:

35 (1) The Administrator of the Aging and Disability Services Division;

36 (2) The Administrator of the Division of Welfare and Supportive Services;

37 (3) The Administrator of the Division of Child and Family Services;

38 (4) The Administrator of the Division of Health Care Financing and
39 Policy; and

40 (5) The Administrator of the Division of Public and Behavioral Health.

41 (b) Shall administer, through the divisions of the Department, the provisions of
42 chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A
43 and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410,
44 inclusive, *and section 9 of this act*, 422.580, 432.010 to 432.133, inclusive,
45 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to
46 445A.055, inclusive, and all other provisions of law relating to the functions of the
47 divisions of the Department, but is not responsible for the clinical activities of the
48 Division of Public and Behavioral Health or the professional line activities of the
49 other divisions.

50 (c) Shall administer any state program for persons with developmental
51 disabilities established pursuant to the Developmental Disabilities Assistance and
52 Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

1 (d) Shall, after considering advice from agencies of local governments and
2 nonprofit organizations which provide social services, adopt a master plan for the
3 provision of human services in this State. The Director shall revise the plan
4 biennially and deliver a copy of the plan to the Governor and the Legislature at the
5 beginning of each regular session. The plan must:

6 (1) Identify and assess the plans and programs of the Department for the
7 provision of human services, and any duplication of those services by federal, state
8 and local agencies;

9 (2) Set forth priorities for the provision of those services;

10 (3) Provide for communication and the coordination of those services
11 among nonprofit organizations, agencies of local government, the State and the
12 Federal Government;

13 (4) Identify the sources of funding for services provided by the Department
14 and the allocation of that funding;

15 (5) Set forth sufficient information to assist the Department in providing
16 those services and in the planning and budgeting for the future provision of those
17 services; and

18 (6) Contain any other information necessary for the Department to
19 communicate effectively with the Federal Government concerning demographic
20 trends, formulas for the distribution of federal money and any need for the
21 modification of programs administered by the Department.

22 (e) May, by regulation, require nonprofit organizations and state and local
23 governmental agencies to provide information regarding the programs of those
24 organizations and agencies, excluding detailed information relating to their budgets
25 and payrolls, which the Director deems necessary for the performance of the duties
26 imposed upon him or her pursuant to this section.

27 (f) Has such other powers and duties as are provided by law.

28 2. Notwithstanding any other provision of law, the Director, or the Director's
29 designee, is responsible for appointing and removing subordinate officers and
30 employees of the Department.

31 **Sec. 7.** NRS 287.010 is hereby amended to read as follows:

32 287.010 1. The governing body of any county, school district, municipal
33 corporation, political subdivision, public corporation or other local governmental
34 agency of the State of Nevada may:

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

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

47 (c) Provide group life, accident or health coverage through a self-insurance
48 reserve fund and, where necessary, deduct contributions to the maintenance of the
49 fund from the compensation of officers and employees and pay the deductions into
50 the fund. The money accumulated for this purpose through deductions from the
51 compensation of officers and employees and contributions of the governing body
52 must be maintained as an internal service fund as defined by NRS 354.543. The
53 money must be deposited in a state or national bank or credit union authorized to

1 transact business in the State of Nevada. Any independent administrator of a fund
2 created under this section is subject to the licensing requirements of chapter 683A
3 of NRS, and must be a resident of this State. Any contract with an independent
4 administrator must be approved by the Commissioner of Insurance as to the
5 reasonableness of administrative charges in relation to contributions collected and
6 benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408,
7 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, *and section 18 of this act*,
8 689B.265, 689B.287 and 689B.500 *and section 11 of this act* apply to coverage
9 provided pursuant to this paragraph, except that the provisions of NRS 689B.0378,
10 689B.03785 and 689B.500 only apply to coverage for active officers and
11 employees of the governing body, or the dependents of such officers and
12 employees.

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

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

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

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

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

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

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

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

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

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

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

50 **Sec. 8.** NRS 287.04335 is hereby amended to read as follows:

51 287.04335 If the Board provides health insurance through a plan of self-
52 insurance, it shall comply with the provisions of NRS 686A.135, 687B.352,
53 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150,

1 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665,
2 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, *and sections 11 and 31*
3 *of this act*, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to
4 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is
5 licensed pursuant to title 57 of NRS is required to comply with those provisions.

6 **Sec. 9.** Chapter 422 of NRS is hereby amended by adding thereto a new
7 section to read as follows:

8 *1. The Director shall include in the State Plan for Medicaid a requirement*
9 *that the State must pay the nonfederal share of expenditures incurred for services*
10 *of a pharmacist that are:*

- 11 *(a) Within the authorized scope of practice of a pharmacist; and*
12 *(b) Reimbursed when provided by another provider of health care.*

13 *2. The State Plan for Medicaid must not limit:*

14 *(a) Coverage for services provided by a pharmacist to a number of occasions*
15 *less than for services provided by another provider of health care.*

16 *(b) Reimbursement for services provided by a pharmacist to an amount less*
17 *than the amount reimbursed for similar services provided by a physician,*
18 *physician assistant or advanced practice registered nurse.*

19 *3. The State Plan for Medicaid must not require a recipient of Medicaid to*
20 *obtain prior authorization for any services provided by a pharmacist that is not*
21 *required for the service when provided by another provider of health care.*

22 *4. As used in this section, "provider of health care" has the meaning*
23 *ascribed to it in NRS 629.031.*

24 **Sec. 10.** NRS 422.27235 is hereby amended to read as follows:

25 422.27235 The Director shall include in the State Plan for Medicaid a
26 requirement that the State pay the nonfederal share of expenditures incurred for ~~f;~~
27 ~~—1.} Any laboratory testing that is necessary for therapy that uses a drug~~
28 ~~approved by the United States Food and Drug Administration for preventing the~~
29 ~~acquisition of human immunodeficiency virus . f; and~~

30 ~~—2. The services of a pharmacist described in NRS 639.28085. The State must~~
31 ~~provide reimbursement for such services at a rate equal to the rate of~~
32 ~~reimbursement provided to a physician, physician assistant or advanced practice~~
33 ~~registered nurse for similar services.}~~

34 **Sec. 11.** Chapter 687B of NRS is hereby amended by adding thereto a new
35 section to read as follows:

36 *1. A health carrier which offers or issues a network plan must demonstrate*
37 *the capacity to adequately deliver services of pharmacists to covered persons in*
38 *accordance with the regulations adopted pursuant to subsection 3.*

39 *2. If a health carrier delegates credentialing agreements to a health care*
40 *facility that is part of the network of the health carrier, the health carrier shall:*

41 *(a) Accept credentialing for pharmacists employed by the health care facility;*
42 *and*

43 *(b) Negotiate in good faith with the health care facility to enter into a*
44 *provider network contract with the health care facility that covers the services of*
45 *those pharmacists.*

46 *3. The Commissioner shall adopt regulations to carry out the provisions of*
47 *this section, including, without limitation, prescribing requirements for a health*
48 *carrier to demonstrate the capacity to adequately deliver services by pharmacists*
49 *to covered persons. Those regulations must not allow a health carrier to*
50 *demonstrate the capacity to adequately deliver such services by demonstrating*
51 *that the health carrier has entered into a network contract with one or more*
52 *pharmacies for the sole purpose of dispensing prescription drugs to covered*
53 *persons.*

1 **4. As used in this section, “health care facility” means any facility licensed**
2 **under chapter 449 of NRS.**

3 **Sec. 12.** NRS 687B.225 is hereby amended to read as follows:

4 687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412,
5 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0315, 689B.0317,
6 689B.0374, 689C.1675, 695A.1856, 695B.1912, 695B.1913, 695B.1914,
7 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1737, 695C.1745,
8 695C.1751, 695G.170, 695G.171, 695G.1714 and 695G.177, **and sections 15, 18,**
9 **20, 23, 25, 27 and 31 of this act**, any contract for group, blanket or individual
10 health insurance or any contract by a nonprofit hospital, medical or dental service
11 corporation or organization for dental care which provides for payment of a certain
12 part of medical or dental care may require the insured or member to obtain prior
13 authorization for that care from the insurer or organization. The insurer or
14 organization shall:

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

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

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

21 **Sec. 13.** NRS 687B.600 is hereby amended to read as follows:

22 687B.600 As used in NRS 687B.600 to 687B.850, inclusive, **and section 11**
23 **of this act**, unless the context otherwise requires, the words and terms defined in
24 NRS 687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those
25 sections.

26 **Sec. 14.** NRS 687B.670 is hereby amended to read as follows:

27 687B.670 If a health carrier offers or issues a network plan, the health carrier
28 shall, with regard to that network plan:

29 1. Comply with all applicable requirements set forth in NRS 687B.600 to
30 687B.850, inclusive **⚡**, **and section 11 of this act**;

31 2. As applicable, ensure that each contract entered into for the purposes of the
32 network plan between a participating provider of health care and the health carrier
33 complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive
34 **⚡**, **and section 11 of this act**; and

35 3. As applicable, ensure that the network plan complies with the requirements
36 set forth in NRS 687B.600 to 687B.850, inclusive **⚡**, **and section 11 of this act**.

37 **Sec. 15.** Chapter 689A of NRS is hereby amended by adding thereto a new
38 section to read as follows:

39 **1. If a policy of health insurance provides coverage for services that are**
40 **within the authorized scope of practice of a pharmacist and which are reimbursed**
41 **when provided by another provider of health care, the insured is entitled to**
42 **reimbursement for services provided by a pharmacist who participates in the**
43 **network plan of the insurer.**

44 **2. The terms of the policy must not limit:**

45 **(a) Coverage for services provided by such a pharmacist to a number of**
46 **occasions less than for services provided by another provider of health care.**

47 **(b) Reimbursement for services provided by such a pharmacist to an amount**
48 **less than the amount reimbursed for similar services provided by a physician,**
49 **physician assistant or advanced practice registered nurse.**

50 **3. A policy of health insurance must not require an insured to obtain prior**
51 **authorization for any service provided by a pharmacist that is not required for the**
52 **service when provided by another provider of health care.**

1 4. A policy of health insurance subject to the provisions of this chapter that
2 is delivered, issued for delivery or renewed on or after January 1, 2024, has the
3 legal effect of including coverage required by subsections 1 and 2, and any
4 provision of the policy that conflicts with the provisions of this section is void.

5 5. As used in this section:

6 (a) "Network plan" means a policy of health insurance offered by an insurer
7 under which the financing and delivery of medical care, including items and
8 services paid for as medical care, are provided, in whole or in part, through a
9 defined set of providers under contract with the insurer. The term does not
10 include an arrangement for the financing of premiums.

11 (b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

12 **Sec. 16.** NRS 689A.0437 is hereby amended to read as follows:

13 689A.0437 1. An insurer that offers or issues a policy of health insurance
14 shall include in the policy coverage for:

15 (a) Drugs approved by the United States Food and Drug Administration for
16 preventing the acquisition of human immunodeficiency virus; **and**

17 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~;~~
18 **and**

19 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist~~
20 ~~who participates in the network plan of the insurer.]~~

21 2. ~~[An insurer that offers or issues a policy of health insurance shall reimburse~~
22 ~~a pharmacist who participates in the network plan of the insurer for the services~~
23 ~~described in NRS 639.28085 at a rate equal to the rate of reimbursement provided~~
24 ~~to a physician, physician assistant or advanced practice registered nurse for similar~~
25 ~~services.]~~

26 ~~—3.]~~ An insurer may subject the benefits required by subsection 1 to reasonable
27 medical management techniques.

28 ~~[4.]~~ 3. An insurer shall ensure that the benefits required by subsection 1 are
29 made available to an insured through a provider of health care who participates in
30 the network plan of the insurer.

31 ~~[5.]~~ 4. A policy of health insurance subject to the provisions of this chapter
32 that is delivered, issued for delivery or renewed on or after October 1, 2021, has the
33 legal effect of including the coverage required by subsection 1, and any provision
34 of the policy that conflicts with the provisions of this section is void.

35 ~~[6.]~~ 5. As used in this section:

36 (a) "Medical management technique" means a practice which is used to control
37 the cost or use of health care services or prescription drugs. The term includes,
38 without limitation, the use of step therapy, prior authorization and categorizing
39 drugs and devices based on cost, type or method of administration.

40 (b) "Network plan" means a policy of health insurance offered by an insurer
41 under which the financing and delivery of medical care, including items and
42 services paid for as medical care, are provided, in whole or in part, through a
43 defined set of providers under contract with the insurer. The term does not include
44 an arrangement for the financing of premiums.

45 (c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

46 **Sec. 17.** NRS 689A.330 is hereby amended to read as follows:

47 689A.330 If any policy is issued by a domestic insurer for delivery to a
48 person residing in another state, and if the insurance commissioner or
49 corresponding public officer of that other state has informed the Commissioner that
50 the policy is not subject to approval or disapproval by that officer, the
51 Commissioner may by ruling require that the policy meet the standards set forth in
52 NRS 689A.030 to 689A.320, inclusive ~~[4]~~, **and section 15 of this act.**

1 **Sec. 18.** Chapter 689B of NRS is hereby amended by adding thereto a new
2 section to read as follows:

3 1. *If a policy of group health insurance provides coverage for services that*
4 *are within the authorized scope of practice of a pharmacist and which are*
5 *reimbursed when provided by another provider of health care, the insured is*
6 *entitled to reimbursement for services provided by a pharmacist who participates*
7 *in the network plan of the insurer.*

8 2. *The terms of the policy must not limit:*

9 (a) *Coverage for services provided by such a pharmacist to a number of*
10 *occasions less than for services provided by another provider of health care.*

11 (b) *Reimbursement for services provided by such a pharmacist to an amount*
12 *less than the amount reimbursed for similar services provided by a physician,*
13 *physician assistant or advanced practice registered nurse.*

14 3. *A policy of group health insurance must not require an insured to obtain*
15 *prior authorization for any service provided by a pharmacist that is not required*
16 *for the service when provided by another provider of health care.*

17 4. *A policy of group health insurance subject to the provisions of this*
18 *chapter that is delivered, issued for delivery or renewed on or after January 1,*
19 *2024, has the legal effect of including coverage required by subsections 1 and 2,*
20 *and any provision of the policy that conflicts with the provisions of this section is*
21 *void.*

22 5. *As used in this section:*

23 (a) *“Network plan” means a policy of group health insurance offered by an*
24 *insurer under which the financing and delivery of medical care, including items*
25 *and services paid for as medical care, are provided, in whole or in part, through a*
26 *defined set of providers under contract with the insurer. The term does not*
27 *include an arrangement for the financing of premiums.*

28 (b) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

29 **Sec. 19.** NRS 689B.0312 is hereby amended to read as follows:

30 689B.0312 1. An insurer that offers or issues a policy of group health
31 insurance shall include in the policy coverage for:

32 (a) Drugs approved by the United States Food and Drug Administration for
33 preventing the acquisition of human immunodeficiency virus; **and**

34 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~and~~
35 **and**

36 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist~~
37 ~~who participates in the network plan of the insurer.]~~

38 2. ~~[An insurer that offers or issues a policy of group health insurance shall~~
39 ~~reimburse a pharmacist who participates in the network plan of the insurer for the~~
40 ~~services described in NRS 639.28085 at a rate equal to the rate of reimbursement~~
41 ~~provided to a physician, physician assistant or advanced practice registered nurse~~
42 ~~for similar services.~~

43 ~~—3.]~~ An insurer may subject the benefits required by subsection 1 to reasonable
44 medical management techniques.

45 ~~[4.]~~ 3. An insurer shall ensure that the benefits required by subsection 1 are
46 made available to an insured through a provider of health care who participates in
47 the network plan of the insurer.

48 ~~[5.]~~ 4. A policy of group health insurance subject to the provisions of this
49 chapter that is delivered, issued for delivery or renewed on or after October 1, 2021,
50 has the legal effect of including the coverage required by subsection 1, and any
51 provision of the policy that conflicts with the provisions of this section is void.

52 ~~[6.]~~ 5. As used in this section:

1 (a) “Medical management technique” means a practice which is used to control
2 the cost or use of health care services or prescription drugs. The term includes,
3 without limitation, the use of step therapy, prior authorization and categorizing
4 drugs and devices based on cost, type or method of administration.

5 (b) “Network plan” means a policy of group health insurance offered by an
6 insurer under which the financing and delivery of medical care, including items and
7 services paid for as medical care, are provided, in whole or in part, through a
8 defined set of providers under contract with the insurer. The term does not include
9 an arrangement for the financing of premiums.

10 (c) “Provider of health care” has the meaning ascribed to it in NRS 629.031.

11 **Sec. 20.** Chapter 689C of NRS is hereby amended by adding thereto a new
12 section to read as follows:

13 *1. If a health benefit plan provides coverage for services that are within the*
14 *authorized scope of practice of a pharmacist and which are reimbursed when*
15 *provided by another provider of health care, the insured is entitled to*
16 *reimbursement for services provided by a pharmacist who participates in the*
17 *network plan of the carrier.*

18 *2. The terms of the plan must not limit:*

19 *(a) Coverage for services provided by such a pharmacist to a number of*
20 *occasions less than for services provided by another provider of health care.*

21 *(b) Reimbursement for services provided by such a pharmacist to an amount*
22 *less than the amount reimbursed for similar services provided by a physician,*
23 *physician assistant or advanced practice registered nurse.*

24 *3. A health benefit plan must not require an insured to obtain prior*
25 *authorization for any service provided by a pharmacist that is not required for the*
26 *service when provided by another provider of health care.*

27 *4. A health benefit plan subject to the provisions of this chapter that is*
28 *delivered, issued for delivery or renewed on or after January 1, 2024, has the*
29 *legal effect of including coverage required by subsections 1 and 2, and any*
30 *provision of the plan that conflicts with the provisions of this section is void.*

31 *5. As used in this section:*

32 *(a) “Network plan” means a health benefit plan offered by a carrier under*
33 *which the financing and delivery of medical care, including items and services*
34 *paid for as medical care, are provided, in whole or in part, through a defined set*
35 *of providers under contract with the carrier. The term does not include an*
36 *arrangement for the financing of premiums.*

37 *(b) “Provider of health care” has the meaning ascribed to it in NRS 629.031.*

38 **Sec. 21.** NRS 689C.1671 is hereby amended to read as follows:

39 689C.1671 1. A carrier that offers or issues a health benefit plan shall
40 include in the plan coverage for:

41 (a) Drugs approved by the United States Food and Drug Administration for
42 preventing the acquisition of human immunodeficiency virus; **and**

43 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~and~~
44 **and**

45 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist~~
46 ~~who participates in the health benefit plan of the carrier.]~~

47 ~~2. [A carrier that offers or issues a health benefit plan shall reimburse a~~
48 ~~pharmacist who participates in the health benefit plan of the carrier for the services~~
49 ~~described in NRS 639.28085 at a rate equal to the rate of reimbursement provided~~
50 ~~to a physician, physician assistant or advanced practice registered nurse for similar~~
51 ~~services.~~

52 ~~—3.]~~ A carrier may subject the benefits required by subsection 1 to reasonable
53 medical management techniques.

~~4.]~~ 3. A carrier shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

~~5.]~~ 4. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2021, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

~~6.]~~ 5. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

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

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 22. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, *and section 20 of this act* to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 23. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a benefit contract provides coverage for services that are within the authorized scope of practice of a pharmacist and which are reimbursed when provided by another provider of health care, the insured is entitled to reimbursement for services provided by a pharmacist who participates in the network plan of the society.

2. The terms of the contract must not limit:

(a) Coverage for services provided by such a pharmacist to a number of occasions less than for services provided by another provider of health care.

(b) Reimbursement for services provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

3. A benefit contract must not require an insured to obtain prior authorization for any service provided by a pharmacist that is not required for the service when provided by another provider of health care.

4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including coverage required by subsections 1 and 2, and any provision of the contract that conflicts with the provisions of this section is void.

5. As used in this section:

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

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

1 **Sec. 24.** NRS 695A.1843 is hereby amended to read as follows:

2 695A.1843 1. A society that offers or issues a benefit contract shall include
3 in the benefit coverage for:

4 (a) Drugs approved by the United States Food and Drug Administration for
5 preventing the acquisition of human immunodeficiency virus; *and*

6 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~f~~
7 *and*

8 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist
9 who participates in the network plan of the society.]~~

10 2. ~~[A society that offers or issues a benefit contract shall reimburse a
11 pharmacist who participates in the network plan of the society for the services
12 described in NRS 639.28085 at a rate equal to the rate of reimbursement provided
13 to a physician, physician assistant or advanced practice registered nurse for similar
14 services.]~~

15 ~~—3.]~~ A society may subject the benefits required by subsection 1 to reasonable
16 medical management techniques.

17 ~~[4.]~~ 3. A society shall ensure that the benefits required by subsection 1 are
18 made available to an insured through a provider of health care who participates in
19 the network plan of the society.

20 ~~[5.]~~ 4. A benefit contract subject to the provisions of this chapter that is
21 delivered, issued for delivery or renewed on or after October 1, 2021, has the legal
22 effect of including the coverage required by subsection 1, and any provision of the
23 plan that conflicts with the provisions of this section is void.

24 ~~[6.]~~ 5. As used in this section:

25 (a) “Medical management technique” means a practice which is used to control
26 the cost or use of health care services or prescription drugs. The term includes,
27 without limitation, the use of step therapy, prior authorization and categorizing
28 drugs and devices based on cost, type or method of administration.

29 (b) “Network plan” means a benefit contract offered by a society under which
30 the financing and delivery of medical care, including items and services paid for as
31 medical care, are provided, in whole or in part, through a defined set of providers
32 under contract with the society. The term does not include an arrangement for the
33 financing of premiums.

34 (c) “Provider of health care” has the meaning ascribed to it in NRS 629.031.

35 **Sec. 25.** Chapter 695B of NRS is hereby amended by adding thereto a new
36 section to read as follows:

37 1. *If a policy of health insurance provides coverage for services that are
38 within the authorized scope of practice of a pharmacist and which are reimbursed
39 when provided by another provider of health care, the insured is entitled to
40 reimbursement for services provided by a pharmacist who participates in the
41 network plan of the hospital or medical services corporation.*

42 2. *The terms of the policy must not limit:*

43 (a) *Coverage for services provided by such a pharmacist to a number of
44 occasions less than for services provided by another provider of health care.*

45 (b) *Reimbursement for services provided by such a pharmacist to an amount
46 less than the amount reimbursed for similar services provided by a physician,
47 physician assistant or advanced practice registered nurse.*

48 3. *A policy of health insurance must not require an insured to obtain prior
49 authorization for any service provided by a pharmacist that is not required for the
50 service when provided by another provider of health care.*

51 4. *A policy of health insurance subject to the provisions of this chapter that
52 is delivered, issued for delivery or renewed on or after January 1, 2024, has the*

1 *legal effect of including coverage required by subsections 1 and 2, and any*
2 *provision of the policy that conflicts with the provisions of this section is void.*

3 5. As used in this section:

4 (a) *“Network plan” means a policy of health insurance offered by a hospital*
5 *or medical services corporation under which the financing and delivery of*
6 *medical care, including items and services paid for as medical care, are provided,*
7 *in whole or in part, through a defined set of providers under contract with the*
8 *hospital or medical services corporation. The term does not include an*
9 *arrangement for the financing of premiums.*

10 (b) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

11 **Sec. 26.** NRS 695B.1924 is hereby amended to read as follows:

12 695B.1924 1. A hospital or medical services corporation that offers or
13 issues a policy of health insurance shall include in the policy coverage for:

14 (a) Drugs approved by the United States Food and Drug Administration for
15 preventing the acquisition of human immunodeficiency virus; **and**

16 (b) Laboratory testing that is necessary for therapy using such a drug. ~~and~~

17 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist~~
18 ~~who participates in the network plan of the hospital or medical services~~
19 ~~corporation.]~~

20 2. ~~[A hospital or medical services corporation that offers or issues a policy of~~
21 ~~health insurance shall reimburse a pharmacist who participates in the network plan~~
22 ~~of the hospital or medical services corporation for the services described in NRS~~
23 ~~639.28085 at a rate equal to the rate of reimbursement provided to a physician,~~
24 ~~physician assistant or advanced practice registered nurse for similar services.~~

25 ~~—3.]~~ A hospital or medical services corporation may subject the benefits
26 required by subsection 1 to reasonable medical management techniques.

27 ~~[4.]~~ 3. A hospital or medical services corporation shall ensure that the
28 benefits required by subsection 1 are made available to an insured through a
29 provider of health care who participates in the network plan of the hospital or
30 medical services corporation.

31 ~~[5.]~~ 4. A policy of health insurance subject to the provisions of this chapter
32 that is delivered, issued for delivery or renewed on or after October 1, 2021, has the
33 legal effect of including the coverage required by subsection 1, and any provision
34 of the policy that conflicts with the provisions of this section is void.

35 ~~[6.]~~ 5. As used in this section:

36 (a) “Medical management technique” means a practice which is used to control
37 the cost or use of health care services or prescription drugs. The term includes,
38 without limitation, the use of step therapy, prior authorization and categorizing
39 drugs and devices based on cost, type or method of administration.

40 (b) “Network plan” means a policy of health insurance offered by a hospital or
41 medical services corporation under which the financing and delivery of medical
42 care, including items and services paid for as medical care, are provided, in whole
43 or in part, through a defined set of providers under contract with the hospital or
44 medical services corporation. The term does not include an arrangement for the
45 financing of premiums.

46 (c) “Provider of health care” has the meaning ascribed to it in NRS 629.031.

47 **Sec. 27.** Chapter 695C of NRS is hereby amended by adding thereto a new
48 section to read as follows:

49 1. *If a health care plan provides coverage for services that are within the*
50 *authorized scope of practice of a pharmacist and which are reimbursed when*
51 *provided by another provider of health care, the enrollee is entitled to*
52 *reimbursement for services provided by a pharmacist in the network plan of the*
53 *health maintenance organization.*

1 2. *The terms of the plan must not limit:*

2 (a) *Coverage for services provided by such a pharmacist to a number of*
3 *occasions less than for services provided by another provider of health care.*

4 (b) *Reimbursement for services provided by such a pharmacist to an amount*
5 *less than the amount reimbursed for similar services provided by a physician,*
6 *physician assistant or advanced practice registered nurse.*

7 3. *A health care plan must not require an enrollee to obtain prior*
8 *authorization for any service provided by a pharmacist that is not required for the*
9 *service when provided by another provider of health care.*

10 4. *A health care plan subject to the provisions of this chapter that is*
11 *delivered, issued for delivery or renewed on or after January 1, 2024, has the*
12 *legal effect of including coverage required by subsections 1 and 2, and any*
13 *provision of the plan that conflicts with the provisions of this section is void.*

14 5. *As used in this section:*

15 (a) *“Network plan” means a health care plan offered by a health*
16 *maintenance organization under which the financing and delivery of medical*
17 *care, including items and services paid for as medical care, are provided, in*
18 *whole or in part, through a defined set of providers under contract with the*
19 *health maintenance organization. The term does not include an arrangement for*
20 *the financing of premiums.*

21 (b) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

22 **Sec. 28.** NRS 695C.050 is hereby amended to read as follows:

23 695C.050 1. Except as otherwise provided in this chapter or in specific
24 provisions of this title, the provisions of this title are not applicable to any health
25 maintenance organization granted a certificate of authority under this chapter. This
26 provision does not apply to an insurer licensed and regulated pursuant to this title
27 except with respect to its activities as a health maintenance organization authorized
28 and regulated pursuant to this chapter.

29 2. Solicitation of enrollees by a health maintenance organization granted a
30 certificate of authority, or its representatives, must not be construed to violate any
31 provision of law relating to solicitation or advertising by practitioners of a healing
32 art.

33 3. Any health maintenance organization authorized under this chapter shall
34 not be deemed to be practicing medicine and is exempt from the provisions of
35 chapter 630 of NRS.

36 4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693,
37 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733,
38 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to
39 695C.200, inclusive, and 695C.265 do not apply to a health maintenance
40 organization that provides health care services through managed care to recipients
41 of Medicaid under the State Plan for Medicaid or insurance pursuant to the
42 Children’s Health Insurance Program pursuant to a contract with the Division of
43 Health Care Financing and Policy of the Department of Health and Human
44 Services. This subsection does not exempt a health maintenance organization from
45 any provision of this chapter for services provided pursuant to any other contract.

46 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, *and section 27*
47 *of this act*, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333,
48 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and
49 695C.1757 apply to a health maintenance organization that provides health care
50 services through managed care to recipients of Medicaid under the State Plan for
51 Medicaid.

1 **Sec. 29.** NRS 695C.1743 is hereby amended to read as follows:

2 695C.1743 1. A health maintenance organization that offers or issues a
3 health care plan shall include in the plan coverage for:

4 (a) Drugs approved by the United States Food and Drug Administration for
5 preventing the acquisition of human immunodeficiency virus; *and*

6 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~f~~
7 *and*

8 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist
9 who participates in the network plan of the health maintenance organization.]~~

10 2. ~~[A health maintenance organization that offers or issues a health care plan
11 shall reimburse a pharmacist who participates in the network plan of the health
12 maintenance organization for the services described in NRS 639.28085 at a rate
13 equal to the rate of reimbursement provided to a physician, physician assistant or
14 advanced practice registered nurse for similar services.~~

15 ~~—3.]~~ A health maintenance organization may subject the benefits required by
16 subsection 1 to reasonable medical management techniques.

17 ~~[4.]~~ 3. A health maintenance organization shall ensure that the benefits
18 required by subsection 1 are made available to an enrollee through a provider of
19 health care who participates in the network plan of the health maintenance
20 organization.

21 ~~[5.]~~ 4. A health care plan subject to the provisions of this chapter that is
22 delivered, issued for delivery or renewed on or after October 1, 2021, has the legal
23 effect of including the coverage required by subsection 1, and any provision of the
24 plan that conflicts with the provisions of this section is void.

25 ~~[6.]~~ 5. As used in this section:

26 (a) “Medical management technique” means a practice which is used to control
27 the cost or use of health care services or prescription drugs. The term includes,
28 without limitation, the use of step therapy, prior authorization and categorizing
29 drugs and devices based on cost, type or method of administration.

30 (b) “Network plan” means a health care plan offered by a health maintenance
31 organization under which the financing and delivery of medical care, including
32 items and services paid for as medical care, are provided, in whole or in part,
33 through a defined set of providers under contract with the health maintenance
34 organization. The term does not include an arrangement for the financing of
35 premiums.

36 (c) “Provider of health care” has the meaning ascribed to it in NRS 629.031.

37 **Sec. 30.** NRS 695C.330 is hereby amended to read as follows:

38 695C.330 1. The Commissioner may suspend or revoke any certificate of
39 authority issued to a health maintenance organization pursuant to the provisions of
40 this chapter if the Commissioner finds that any of the following conditions exist:

41 (a) The health maintenance organization is operating significantly in
42 contravention of its basic organizational document, its health care plan or in a
43 manner contrary to that described in and reasonably inferred from any other
44 information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless
45 any amendments to those submissions have been filed with and approved by the
46 Commissioner;

47 (b) The health maintenance organization issues evidence of coverage or uses a
48 schedule of charges for health care services which do not comply with the
49 requirements of NRS 695C.1691 to 695C.200, inclusive, *and section 27 of this act,*
50 *or 695C.207;*

51 (c) The health care plan does not furnish comprehensive health care services as
52 provided for in NRS 695C.060;

53 (d) The Commissioner certifies that the health maintenance organization:

- 1 (1) Does not meet the requirements of subsection 1 of NRS 695C.080; or
2 (2) Is unable to fulfill its obligations to furnish health care services as
3 required under its health care plan;
- 4 (e) The health maintenance organization is no longer financially responsible
5 and may reasonably be expected to be unable to meet its obligations to enrollees or
6 prospective enrollees;
- 7 (f) The health maintenance organization has failed to put into effect a
8 mechanism affording the enrollees an opportunity to participate in matters relating
9 to the content of programs pursuant to NRS 695C.110;
- 10 (g) The health maintenance organization has failed to put into effect the system
11 required by NRS 695C.260 for:
- 12 (1) Resolving complaints in a manner reasonably to dispose of valid
13 complaints; and
14 (2) Conducting external reviews of adverse determinations that comply
15 with the provisions of NRS 695G.241 to 695G.310, inclusive;
- 16 (h) The health maintenance organization or any person on its behalf has
17 advertised or merchandised its services in an untrue, misrepresentative, misleading,
18 deceptive or unfair manner;
- 19 (i) The continued operation of the health maintenance organization would be
20 hazardous to its enrollees or creditors or to the general public;
- 21 (j) The health maintenance organization fails to provide the coverage required
22 by NRS 695C.1691; or
- 23 (k) The health maintenance organization has otherwise failed to comply
24 substantially with the provisions of this chapter.
- 25 2. A certificate of authority must be suspended or revoked only after
26 compliance with the requirements of NRS 695C.340.
- 27 3. If the certificate of authority of a health maintenance organization is
28 suspended, the health maintenance organization shall not, during the period of that
29 suspension, enroll any additional groups or new individual contracts, unless those
30 groups or persons were contracted for before the date of suspension.
- 31 4. If the certificate of authority of a health maintenance organization is
32 revoked, the organization shall proceed, immediately following the effective date of
33 the order of revocation, to wind up its affairs and shall conduct no further business
34 except as may be essential to the orderly conclusion of the affairs of the
35 organization. It shall engage in no further advertising or solicitation of any kind.
36 The Commissioner may, by written order, permit such further operation of the
37 organization as the Commissioner may find to be in the best interest of enrollees to
38 the end that enrollees are afforded the greatest practical opportunity to obtain
39 continuing coverage for health care.
- 40 **Sec. 31.** Chapter 695G of NRS is hereby amended by adding thereto a new
41 section to read as follows:
- 42 *1. If a health care plan provides coverage for services that are within the*
43 *authorized scope of practice of a pharmacist and which are reimbursed when*
44 *provided by another provider of health care, the insured is entitled to*
45 *reimbursement for services provided by a pharmacist who participates in the*
46 *network plan of the managed care organization.*
- 47 *2. The terms of the plan must not limit:*
- 48 *(a) Coverage for services provided by such a pharmacist to a number of*
49 *occasions less than for services provided by another provider of health care.*
- 50 *(b) Reimbursement for services provided by such a pharmacist to an amount*
51 *less than the amount reimbursed for similar services provided by a physician,*
52 *physician assistant or advanced practice registered nurse.*

1 **3. A health care plan must not require an insured to obtain prior**
2 **authorization for any service provided by a pharmacist that is not required for the**
3 **service when provided by another provider of health care.**

4 **4. A health care plan subject to the provisions of this chapter that is**
5 **delivered, issued for delivery or renewed on or after January 1, 2024, has the**
6 **legal effect of including coverage required by subsections 1 and 2, and any**
7 **provision of the plan that conflicts with the provisions of this section is void.**

8 **5. As used in this section:**

9 **(a) "Network plan" means a health care plan offered by a managed care**
10 **organization under which the financing and delivery of medical care, including**
11 **items and services paid for as medical care, are provided, in whole or in part,**
12 **through a defined set of providers under contract with the managed care**
13 **organization. The term does not include an arrangement for the financing of**
14 **premiums.**

15 **(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.**

16 **Sec. 32.** NRS 695G.1705 is hereby amended to read as follows:

17 695G.1705 1. A managed care organization that offers or issues a health
18 care plan shall include in the plan coverage for:

19 (a) Drugs approved by the United States Food and Drug Administration for
20 preventing the acquisition of human immunodeficiency virus; **and**

21 (b) Laboratory testing that is necessary for therapy that uses such a drug . ~~;~~
22 **and**

23 ~~—(c) The services described in NRS 639.28085, when provided by a pharmacist~~
24 ~~who participates in the network plan of the managed care organization.]~~

25 ~~2. [A managed care organization that offers or issues a health care plan shall~~
26 ~~reimburse a pharmacist who participates in the network plan of the managed care~~
27 ~~organization for the services described in NRS 639.28085 at a rate equal to the rate~~
28 ~~of reimbursement provided to a physician, physician assistant or advanced practice~~
29 ~~registered nurse for similar services.]~~

30 ~~—3.] A managed care organization may subject the benefits required by~~
31 ~~subsection 1 to reasonable medical management techniques.~~

32 ~~[4.] 3. A managed care organization shall ensure that the benefits required by~~
33 ~~subsection 1 are made available to an insured through a provider of health care who~~
34 ~~participates in the network plan of the managed care organization.~~

35 ~~[5.] 4. A health care plan subject to the provisions of this chapter that is~~
36 ~~delivered, issued for delivery or renewed on or after October 1, 2021, has the legal~~
37 ~~effect of including the coverage required by subsection 1, and any provision of the~~
38 ~~plan that conflicts with the provisions of this section is void.~~

39 ~~[6.] 5. As used in this section:~~

40 ~~(a) "Medical management technique" means a practice which is used to control~~
41 ~~the cost or use of health care services or prescription drugs. The term includes,~~
42 ~~without limitation, the use of step therapy, prior authorization and categorizing~~
43 ~~drugs and devices based on cost, type or method of administration.~~

44 ~~(b) "Network plan" means a health care plan offered by a managed care~~
45 ~~organization under which the financing and delivery of medical care, including~~
46 ~~items and services paid for as medical care, are provided, in whole or in part,~~
47 ~~through a defined set of providers under contract with the managed care~~
48 ~~organization. The term does not include an arrangement for the financing of~~
49 ~~premiums.~~

50 ~~(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.~~

51 **Sec. 33.** The provisions of NRS 354.599 do not apply to any additional
52 expenses of a local government that are related to the provisions of this act.

53 **Sec. 34.** 1. This section becomes effective upon passage and approval.

- 1 2. Sections 1 to 33, inclusive, of this act become effective:
2 (a) Upon passage and approval for the purpose of adopting any regulations and
3 performing any other preparatory administrative tasks that are necessary to carry
4 out the provisions of this act; and
5 (b) On January 1, 2024, for all other purposes.